Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 13001 State
 Registrar Certificate of Death 2. Date of Death Physician/ Month Susan Rebecca HORNBAKER April 3:15 P M ,2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 217-30-5905 **Director** 76 May 11, 1935 **Maryland** Usual Residence of Decedent or 28a-f show notified at should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Franklin 1 Yes 2X No Mercersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 13820 Blairs Valley Road 17236 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married ☐ Yes 2 🕱 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: white Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the <u>Medical</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) nursing aid hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold James Mills Helen Marie Carbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Hornbaker - Step Son 13782 Blairs_Valley Road, Mercersburg, Pa._17236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 4/14/12 Hagerstown, Maryland _Lawn Mem.Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Maryland 21740 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ HEPATIC ENCEPHALOPATHI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Examine but to (or as a consequence of): HYPOXEMI+ To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical RE VTE NAL Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? **Director:** After this certificate d in by the funeral director, pag 2 - No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🔯 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1上 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 뎙 Certifying Physīcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Frantitioners To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MOHAMMED 66892 A212 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TW-K) 11116 Medical Campus Rd. Hagerstown AZIZ MD istrar's Signature **State**

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 13002 For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Howard William HURD Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown 13930 Pennsylvania Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, 1 🗶 M 2 🗆 F Days Hours Maryland 926 **Director** 85 Oct. 220-18-1999 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a USA 21742 13930 Pennsylvania Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 ☐ Never Married 2 🏋 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. 3 Widowed 4 Divorced 1945-46 White Completed Year or Dates. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Labor Furniture Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Corderman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Chester Franklin Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Hurd - Wife 13930 Pennsylvania Avenue, Hagerstown, Md. 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawn Mem. Park | 4/16/2012 |Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licer 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ingestive Medical resulting in death) Due to (or a a consequence of) **Examiner** Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequent ed by the attending physician and detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu<mark>re and title of certif</mark>ie D0041131

Registrar
DHMH 17 Rev 7/2009

30. Name a

Compus

mo

Hagerstown

d address of person who completed cause of death (Item 23a) (Type, Print) IIIO Medrew

M.D

CORRECES

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 State of Maryland / Department of Health and Mental Hygiene

Linda Wis	mer H		1- For State	tate of Maryla		artment of		nd Mental		See V	J 1 L 1 0 0 0
P	hysici	an/	Registrar 1. Decedent's Name (First, Midd	dle,Last)					2. Date of Dea Month		3. Time of Death
Medical	Exami	ner	Linda Jean Ho	werton					April 8, 20	012 1	1809 nrs
)			4a. Facility Name (if not instituti 1008 F Security Road		umber)	1	4b. City, Town, or Hagerstow		ath	4c. County o Washing	
Fu	ineral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yes		Irs. 8. Date of Bi	_	9. Birthplace (State or Foreign Washing ton
	ector		231-68-7712	1_M 2XF	58	Yrs	Months Day	s Hours N	July	2,1953	Foreign WASHING LOIN Country) D.C
			Usual Residence of Decedent		l						D. 0.
	DW any		10a. State 10b. County Maryland Washi			, Town or Locat Serstown					10d. Inside City Limits 1 Yes 2 X No
ryland	28a-f show d at once.	흃	10e. Street and Number		10) 110.2		10f. Zip Code		11	0g. Citizen of Wha	
the Ma	or 28	Director	1008 F Securi	ty Blvd.			21740	О		U.S.A.	-
with	or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status		cedent Ever in U		s Decedent of Hi es, specify Cubar		Specify Yes or No		- American Indian, Black,
r death	or ite	E	1 Never Married 2 X N	1 Yes	2 X No				no Ricari, etc.)	White,	
ırs afte	ural",	à.	3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Yes or Dates: ecify only highest gra			Yes 2 X No		of work done	Specify: 16b. Kind of Bus	White
72 hou	E	etec	Elementary/Secondary (0-12)				ost of working life			2	·
036 vithin	ene.	Completed		2		Homen	naker				al Residence
21215-0036 July be filed within 7	T the		17. Father's Name (First, Middle Carl Wismer	, Last)					me (First, Middle, 1 Jean Bowe		
212 and be	Menta mark c even	To Be	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stree	_			, State, Zip Code)
MD d 2 shor	Ith and 27 is		Elizabeth J.	Kees-daugl						n, MD 217	
.s 1 and	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal fr		Place of Dispos crematory or oth	ition (Name of ce ner place)	metery,	Date	20c. Location - (City or Town, State
Baltimore, permit. Pages 1 ar	tant:		4 Donation 5 Other S	pecify:	S	mithsbu	rg Crema	tory 4	-11-2012	Smithsb	urg, MD Funeral Home
Ball permit	Injury o	1	21. Signature of Funeral Service	Licensee	1	1 22. N	ame and Addres	s of Facility	ouglas A	. Fiery Hagersto	wn, MD 21742
Phys	ician		23a. Part I. Enter the disease of		aused the death						rt Approximate Interval
JMe	dical niner		failure. List only one cause Immediate Cause (Final disease	O 41:	und of neck						Between Onset and Death
, , , Adi	iiiiei		or condition resulting in death)	Due to (or as a	consequence o	of):					
		ē	Sequentially list conditions, if any, leading to immediate		consequence of	of):					
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	6	consequence o	of).					
uted	n and - transit	Ä	events resulting in death) Last	d	· control quonto c						
), be executed	sician a	edical	UNPENDED	AMENDED							
	g phys s the b	/Me	IF FEMALE: 3b. Was decedent pregnant in t		outcome of preg		tal death 3	Ectopic preg	nancy	23d. Date of d	lelivery Day Year
Box 6876 e death certificate	attending phys for use as the b	icial	past 12 months?	4 Pregr	ant at time of de		ner (Specify)	Lotopic prog	riarioy	World	Day Teal
. ž	y the al	Physician/M	1 Yes 2 No 9 ✔ Un	19 01801		and the second	nderlying cause	sisso in Dest I	220 Did to	shaqaa uga saatsib	ute to the cause of death?
Division of Vital Records, P.O. I	icate has been signed by the att page 2 should be detached for	2	rait II. Other significant condi	contributing to	death but not i	esalting in the a	riderlying cause (given in Farci.			Probably 4 Unknown
rds ,	been si	Completed							24a. Was a		ere autopsy findings available
ecol he law	te has ge 2 sl	m d							autop perfor 1 ✓ Yes	med? de	ior to completion of cause of eath? Yes 2 No
	ertifica stor, pa	Bec	25. Was case referred to medica				26.Place	of Death (Chec			
Vit	After this certificate funeral director, page	၉	examiner? 1 ✓ Yes 2 No		npatient 2	ER/Outpatient				Residence 6	
n of	Afte funer		27. Manner of Death 1 Natural 5 Pen	28a. Date FOUND	of Injury , Day,Year)	28b. Time of Ir FOUND:		ry at Work? Yes 2 ✔ No	Subject cut	now injury occurred self	d
isio	r deam	Cati	2 Accident Inve	stigation Apr 8, 2		1809 hrs ome, farm, stree	t, factory, office b		28f. Location (S	Street and Number	or Rural Route Number, City
Div.	nours arrer uneral Dire y filled in b	Certification:		id not be	Multi-Fami				or Town, S 1008 F Securi	^{tate)} ty Road, Hagers	stown, MD
# 2	\$ E B		(Oriota orin)	hysician: To the bes	_	-					
To th	To the	BL	one) 2 Medical Exa 29b. Signature and title of certific	miner: On the basis of and manner s		ind/or investigati	29c. Licens		at the time, date a		
			Signature and the or certific	2 1	A		O.C.I			April 9, 2012	d (Month, Day, Year)
		-	30. Name and address of person	who completed caus	se of death (Item	123a)					
IW - :	3			Assistant Medic			altimore Stre	et, Baltimore	e, MD 21223		
	St: Regist		31. Date filed (Montil, Div Year)	E ZMIZI A	gistrar's Signatu	ire /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Physician/ April Gail M. Harris 5 1:14 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1334 Taney Ave. #203 Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) Funeral Months (Month, Day, Year) 577-44-4219 76 1 □ M 2 🗓 F **Director** June 9, 1935 Washington, DC Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director oms 23a or 28a-f sh r must be notified a Frederick 1 X Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1334 Taney Ave. #203 21702 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ō. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 'natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Counselor Social Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ဂ္ဂ Frank Ferrara Mildred Dommel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 1334 Taney Ave. #203, Frederick, Maryland 21702 Jeanine Harris / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 4/8/2012 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home onthe 2 a. Par 1. Enter the disast se, or complications that calls dishe death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on exterior.

Immediate Cause (Find disaster or conditions) 1621 Opossumtown Pike, Frederick, MD 21702 Approximate
Interval Between
Onset and Death
Months Physician/ disease or condition resulting in death) 5mal Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, EUMONIA Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 1 Yes Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at al or Attending P s after death. I Director: After ti Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is an article of the cause of Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-

Registrar

State

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 2<u>012</u> Physician/ Barbara Estelle Herbert 7:27 A April Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Edgewater 1126 Mayo Road Year If Under 8. Date of Birth 9. Birthplace (State or Foreign If Unde Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 772271921 1 🗆 M 2 🗓 F 90 Washington, 579-14-0380 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 No Maryland Anne Arundel Edgewater 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21037 3728 Ramsey Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Estelle Schreyer Henry Paul Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3728 Ramsey Drive, Edgewater, MD 21037 Linda F. Lee/ Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory 4/10/12 Edgewater, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions ir any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerform death? Yes 2 X No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 4 Nursing Home 5 Residence 6 Other (Specify) Granddaughter's 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending 1 Yes 2 No 2 🔲 Accident Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D7021 Suela Kaba, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month

10

Annapolis

12-02800 Rodney D. Hill

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2012 13006

		Registrar	e of Death	Reg	g. No.	
Physicia	1/	Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death 1724 hrs
Medical Examin		Rodney DeWeese Hill	Ab City Tour as Leasting of Dooth	April 9, 201	4c. County of Death	17241115
ノ	ı	Facility Name (if not institution, give street and number) Easton Memorial Hospital	4b. City, Town, or Location of Death Easton		Talbot	
Funeral	4	Social Security Number 6. Sex 7. Age (In yrs. last birthd)	ay) If Under 1 Year If Under 24Hrs	8. Date of Birth		nplace (State or
Director		213-76-9196 1XM 2F 53	Yrs. Months Days Hours Min.	May 20,	1958 Foreign	ntry) Maryland
any	F	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location			10d. Inside City Limits
	.	Maryland Talbot Cordov				1 Yes 2 X No
faryland	rector	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
2 . 3	直	31603 Geib Road	21625		USA	
t be n	era	11. Marital Status 1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
er deat	Fune	1 Yes 2 No 3 Widowed 4 Divorced If Yes Give Year	1 Yes 2 No specify:		Specify: Whi	ite
urs afte	<u>a</u>	15. Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Occupation (Give kind of v		16b. Kind of Business/Ir	ndustry
72 hou	et Fe	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use reti	red)	NI / A	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Completed		andicapped		N/A	
filed if Hyging ed oth	Be Be	17. Father's Name (First, Middle, Last) Aaron Godfrey Hill	18.Mother's Name	e (First, Middle, M Ann Hill		
212 uld be Mentz mark			Mailing Address (Street and Number or F			Zip Code)
MD d 2 sho lth and n 27 is					laryland 21	
re, s 1 and f Heal ff iten		1 X Burial 2 Cremation 3 Removal from State crematory	Disposition (Name of cemetery, y or other place)	Date	20c. Location - City or	
Page Page ment coment cor oth	4	4 Donation 5 Other Specify: Fastern	Shore Vet. Cemetery 4/1	Contract of the Contract of th		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	J	2 ature of Funeral Service Licensee 1 mules M Moore	22. Name and Address of Facility M. 12 South 2nd Stree		eral Home, on, Maryla	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not e				Approximate Interval
/Medical	-	failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiovascula				Between Onset and Death
Examiner	-	or condition resulting in death) Due to (or as a consequence of):				
	[ي	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated				
tred d ansit		events resulting in death) Last Due to (or as a consequence of): d.				
of Vital Records, P.O. Box 68760, g. Physician: The law requires that the death certificate be executed fler this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - transit	Medica	UNPENDED AMENDED				
760, cate be physic		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
cath certificate attending	Physician	past 12 months? 1 Live birth 2 4 Pregnant at time of	Fetal death 3 Ectopic pregna Other (Specify)	ancy	Month D	ay Year
Box 68 e death certif the attending)Šį	1 Yes 2 No 9 Unknown 9 Unknown	Officer (opecary)			
P.O. E es that the d igned by the ce detached	o P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		pacco use contribute to	
S, P.C uires that n signed !	8				2 ✓ No 3 Frob	opsy findings available
Cords law requi	Completed			24a. Was a autops perform	sy prior to c	ompletion of cause of
tal Recition: The l	ទ្រ			1 ✓ Yes 2		s 2 No
ician: s certif	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outp	26.Place of Death (Check Deatient 3 DOA Other Nursin		Residence 6 Other	
ing Physical Figure 1 of Virging Physical Figure 1 of Virginia of	위	1 V Yes 2 No 27 Manner of Death 28a. Date of Injury 28b. Tir	me of Injury 28c. Injury at Work?		ow injury occurred	·
– ਛੋ-	틹	1 ✓ Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Division of Vital Records, pital or Attending Physician: The law requirement ours after death. In the certificate has been similar to the funeral director. After this certificate has been similed in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Ru	ral Route Number, City
Spital nours and filled	5	4 Homicide determined (Specify)		0		
Divisior To the Bospital or Attent within 24 hours after death Th the Fineral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 W Medical Examiner: On the basis of examination and/or inv				
To vit	ğ	29b. Sometime and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
		(') (atalemy)	O.C.M.E.		April 10, 2012	
	Ì	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 N	W Baltimore Street Baltimore	MD 21223		¥V 0
Sta	ite		v. Baltimore offeet, Baltimore,			
Registi	ar	31. Date filed (Month, Day Year) 32. Registrar's Signature				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per dr., g926,04/25/2012dbb
Red. No.
Red. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 Physician/ 9:50 BMM nes Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Clinic ND. and Surgical Prince of Southern George If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Security Number **Funeral** (Month, Day, Min. Days Hours Months 82 220-16-8733 Director Usual Residence of Decedent 10d Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director ACCOKEEK PRINCE GEORGES 1 Yes 2 XNo MD. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral U.S.A. 20607 2313 MAPLE CROSS STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Yes 2 X No δ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK If Yes Give 3 Widowed 4X Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) PRINCE GEORGES Elementary/Seconday (0-12) College (1-4 or 5+) CO.SCHOOLD BD. DIETICIAN AIDE 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 MARY CATHERINE JOHNSON JOSEPH MARVIN HEMSLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 2313 MAPLE CROSS ST. ACCOKEEK, MD. 20607 SANDRA WASHINGTON-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
SACRED HEART CEM. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 3-16-12 LA PLATA, MD. 4 Donation 5 Other (Specify) M00479 2 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 21. Signature of Juneral Service Licensee 23á. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) sequence of Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Yea Day Pregnant at time of death Other (specify) 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 s has performed? 2 No 1 Yes After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, **Division of Vital** Be Daughter's examiner? Other: 4 Nursing Home 5 Anesidence 6 NOther (Specifyes idence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ဂ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No Investigation Accident completed filled in by the 24 hours after deat Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 10403 Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

APR 2 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | 30 | 30

		1- For State Registrar	(Certific	cate of	Death			Re	eg. No.		
Physicia ledical Examir	ın/	1. Decedent's Name (First, Middle,La Darren	Ressler		Hess				2. Date of Dear Month April 10, 2	Day Yes		3. Time of Death 1902 hrs
The state of the s		4a. Facility Name (if not institution, gi 5925 Natasha Drive	ve street and number)		41	. City, Town, Berwyn H		of Death		4c. County Prince ('s
Funeral Director		5. Social Security Number 6. S 217-04-3533 1X	Sex 7. Age (In y	rs. last bi	rthday) Yrs.	If Under 1 Y Months D	ear If Under ays Hours	er 24Hrs Min.	8. Date of Bir	th(MM/DD/YYY) /1974	Foreign	
d bow any		Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's		or Location						- 1	10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show	Directo	10e. Street and Number 5925 Natasha		DCIW		10f. Zip Code	207	40	10	0g. Citizen of W		try?
fter death with '', or items 2.	/ Funeral	11. Marital Status 1 Never Married 2 XX Married 3 Widowed 4 Divorce	1 Yes 2 XXN d If Yes, Give Year		If Yes	Decedent of logs, specify Cub	an, Mexican,		ecify Yes or No- Rican, etc.)		e, etc.	an Indian, Black, iite
72 hour	Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	Tor Dates: only highest grade completed College (1-4 or 5+)	\exists	during mos	Usual Occup t of working l ulturi	ife. DO NOT			16b. Kind of Bu		
21215-0036 uld be filed within 72 Mental Hygiene, marked other than '	Be Corn	17. Father's Name (First, Middle, Last James K. H		<u>i</u>				s Name	(First, Middle, N	l Maiden Surname	·)	
re, MD 21215-0036 s 1 and 2 should be filed within fHealth and Mental Hygiene. Uftem 27 is marked other that or traumatic event, the Medic	2	19a. Informant's Name/Relationship (Ann Wooten Hes	** *		_	,	eet and Num	ber or F	ural Route Num	hber, City or Tow ghts , M	, - ,	Zip Code) 0740
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Dogation 5 Other Specify	Removal from State	crema	crem.	atory			Date 9/2012	Lugewa	iter,	Maryland
Balt permit Depart Impor injury		21. Signature of Funeral Service Lice	is. D'		22. Nai 616	ne and Addre	ess of Facility Hill	Rd.	rge P Oxon Hi	Kalas F ill, MD	uner 2074	al Home PA
Physician /Medical xaminer		23a. Part / Enter the disease, or com failure. List only one cause on e Immediate Cause (Final disease a or condition resulting in death)	plications that caused the deach line. Mixed dru- and Morphine. Due to (or as a consequent)Into			g, such as ca Cyclob	ardiac or PENZ	aprine,(est, shock, or he exycodon	art I e	Approximate Interval Between Onset and Death
_ =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a consequent									
execur an and al - tra	Medical E	d d	AMENDED23a,27	,28a-	-f,per	me,g	26 4-3	30-1	2 sm			
Box 68760, re death certificate be extitle attending physician ted for use as the burial	Physician/Med									23d. Date of Month	delivery Da	ay Year
P.C s that gned	3	Part II. Other significant conditions		ot resultir	ng in the und	derlying cause	given in Pa	rt I.				ne cause of death?
of Vital Records, P.O. Box 68' of Physiciae: The law requires that the death certificate has been signed by the attending neral director, page 2 should be detached for use as	Completed								24a. Was a autop: perfor	sy p	nior to co death?	opsy findings available impletion of cause of
	Be C	25. Was case referred to medical examiner?				26.Pla	ce of Death (Check o	nly one)			
F Vid	의	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury		outpatient Time of Inju		Other ₄			Residence 6		Scene
E fr B	atlon:	1 Natural 5 Pending 2 Accident Investigat	(Month, Day, Year) ion fd 4-10-12	fd.	6:20	pm 1	Yes 2	No s	subject	ingetse	d dr	_
Division of Vital Hospital or Atteodiog Physiciae: 24 hours after death. Fuceral Director: After this certif rely filled in by the funeral director.	Certification:	3 X Suicide 6 Could not determine	d (0 .:c)	At home, f side:		factory, office	building, etc	s.	28f. Location (S or Town, Si Berwyn	ate) 5925 H eights	er or Rura Nata: MD.	al Route Number, City sha Dr.
Divisic To the Hospital or Atte within 24 hours after dea To the Fuoeral Director completely filled in by th	Medical	one) 2 Medical Examine	ian: To the best of my know r:On the basis of examination and manner stated.	vledge, de on and/or	eath occurre investigation	n, in my opini	on, death occ	ce, and curred at	due to the cause the time, date a	and place, and d	ue to the	cause(s)
	2	29b. Signature and title of certifier	Iller s				onse number			April 11, 20	1	h, Day, Year)
ф		30. Name and address of person who Patricia Aronica-Pollak M		_	niner 9	00 W. Bali	imore Str	eet, B	altimore, ME	21223		
Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 2012	32. Registrar's Sig	ature	A. C.							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 13009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 Month Mae Harrod Physician/ Leatha 1457 Apri1 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Center Annapolis Anne Arundel Medical If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Country) 217-60-8119 1 2 m 1 3 m 1 9 4 7 64 **Director** 1 □ M 2 **X**) F MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10c. City, Town or Location Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 XNo MD Calvert Huntingtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20639 Funeral 4420 Harvey Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates er than "natural", the Medical Exam 3X Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. ✓al Hygiene. ✓ar than "r Someone Else's Elementary/Secondary (0-12) 12 College (1-4 or 5+) Domestic Home permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygies
Important: If item 27 is marked other 1
any injury or other traumatic event, th Be 18. Mother's Name *(First, Middle, Maid*en *Surname)* Mary Ellen Gross 17. Father's Name (First, Middle, Last) Jones Mary မ Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DE 19701 Bear, Forsythia Lane Almous Harrod/son Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ches.H. Mem.Gar. 14/7/2012 Port Repubic, 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Bch. Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licensee Blade 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ as a consequence of): PRELIMINAS CRAT MU-145 disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the at d be detached f q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by URE UTI Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed PROCERDIAL EFFICION TAMPORADL Were autopsy findings available prior to completion of cause of 24a. Was an METABOLIC Ac.OU.) has autopsy page 2 performed? death? RESPIRATURY FAILURY Hospital or Attending Physician: The 24 hours after death.
 Funeral Director. After this certificate I Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 🗌 Yes 2 200 ဂ္ 1 Dopatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 \(\subseteq \text{Yes} \) Date of injury (Month, Day, Year) 28b. Time of 28a. Date of Certificate: 28d. Describe how injury occurred 5 Pending To the Hospital or Attendir within 24 hours af er death.

To the Funeral Director. Af completely filled it by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 2199

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

PATGE

APR 2 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ April 7 LO: DO AM Angela G. Henkel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford <u> Harford Memorial Hospita</u> de Grace <u>Havre</u> 9. Birthplace (State or Foreign Country) New Jersey Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth Funeral 1 1 M 2 1 F 07/09/1936 Director 145-28-4228 76 Jsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If item 27 is marked of then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Harford Aberdeen MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21001 700 W BelAir Avenue, U.S.A Apt 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Aaron Groves Teresa Stoltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Henkel Brandeis Ave., Cinnaminson, NJ 08077 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Suburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u> 04/13/2012 Pennhaven, NJ</u> Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Allowary Funeral Home Maple Avenue, Merchantville, E Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or)as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnapt 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? in ure...in 24 hours after death.

To the Funeral Director. After this certificate I 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ENKEL, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 1 Natural 5 Pending work? 2 Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NESPEEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21018 NION VEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 5 2012 backs Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, 926,04/19/2012dhb Reg. No. 2012 13011 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEB. 15^{Day}2012 MIRIAM FREEDMAN HEVEY 1:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES MED.CENTER CHEVERLY PRINCE GEORGES Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 578-44-6443 (Month, Day, Year) 2-19-1932 Director 1 🗆 M 2 😾 F 79 WASH., D.C. Usual Residence of Decedent 28a-f shov at 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified LA PLATA MD. CHARLES 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral "natural", or items 23a 20646 8843 DOE COURT U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 🔀 Married þ 1 Yes If Yes, Give 2 No Specify: WHITE 1 Yes 2 X No Specify: Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U.S.NAVY marked other than Elementary/Secondary (0-12) College (1-4 or 5+) COURT CLERK (RET.) U.S.GOVT. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental I မ SOL FREEDMAN should be MOLLY BALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 ROBERT H. HEVEY-SPOUSE 8843 DOE COURT LA PLATA, MD. 20646 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OUANTICO NAT. CEM. 2-21-12 OUANTICO, VA. Signature of Funeral Service Licenses M00479 Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying EXAMINE Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ o in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year Yes 2 No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an bage 2 autopsy death? 1 ☐ Yes 2 No 2, No 1 Yes 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury **Found** th, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 X Accident work? 1 ☐ Yes 2**X** No 5 Pending Unknown Multiple falls Investigation 01/24/2012 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 70 Village Street 4 Homicide determined Nursing Home Waldorf,MD Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. death_(Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13012 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 11:27 P M Russell Frederick Irving Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crownsville 556 Palisades Blvd. Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 🗆 F 76 Yrs Hours Country) 3/23/1938 MA **Director** 031-30-3225 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d Inside City Limits Director 1 Yes XX No MD Crownsville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21032 USA 556 Palisades Blvd. Was Decedent ... Armed Forces? 1121 Yes 2 No the tnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2XX Married þ Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes Give 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **CTRCM** US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Russell Irving Sr. Rose Ago 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 sl it of Health a Crownsville, MD 21032 556 Palisades Blvd. Judith Irving Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o MX Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/12 Maryland Veterans Cem Crownsville, MD 4 Donation 5 Other (Specify) Signatore of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION PLLMONART Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) PULMONARY FIBROSIS anding physician and use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) 4 Pregnant Pregnant at time of death the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HIGH CHOLESTEROL 1 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No DIABETES 24a Was an has autopsy performed? this certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

CHSH

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2002

ANDREW MCGLONE, MD

APR 1 0 2012

31. Date filed (Month, Day, Year)

D0062349

2012

APRIL

Parkway suite 670 annopolis MD 2147

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#12perFH,4/13/12; FMW, MbCo 13013 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 4:10 A Seymour Jablon April Medical 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda Montgomery Suburban Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Hours Director 1 🗶 M 2 🗆 F 93 119-05-6365 Yrs. June 2, 1918 New York, NY Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ō ms 23a or must be n Funeral United States 20817 6813 Persimmon Tree Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner med Forces Black, White, etc. or, 1 Never Married 2 Married Yes Give þ 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗙 No Specify: Specify: Caucasian "natural", 3 X Widowed 4 Divorced Completed 1942-45 Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the A ONCE. the National Research Council <u>Medical Statistician</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Anna Rubin Harry Jablon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Zuckerman, Daughter <u> 276 Franklin Street, Newton, MA 02458</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔲 Burial 2 🕱 Cremation 3 🗀 Removal from State Ft. Lincoln Crematory 4/16/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) MO1102 22. Name and Address of Facility Simple Tribute 21. Signatine of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ruptured Abdominal Aortic Aneurysm disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical On Seymour Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown History of sigmoid colon adenocarcinoma 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Hypertension autopsy performe Jas page 2 2 X No 26. Place of Death (Check only one) 25. Was case referred to medica Division of Vital To the Hospital or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral a 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Spelistatlis 91 201 HD D59980 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, Year)

Registrar's Signa

Delistatuis 8600 Old Georgetown Road 4th Floor, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2012 FRANCES WEBB JOHNSON APRIL 21:35PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CECIL ELKTON ELKTON CARE AND REHAB 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number **Funeral** (Month, Day, Year)
UNE 12,1926 Months Days Hours 1 □ M 2 🗓 Yrs. **Director** PENNSYLVANIA JUNE 197-12-1860 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location with the Maryland 10a, State 10d. Inside City Limits Director 1 Yes 2 X No CECII MARYLAND NORTH EAST o 10e, Street and Number 10f, Zip Code 10q. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 309 STONEY COURT UNITED STATES 21901 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. WHITE Specify: Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) SCHOOL BUS DRIVER TRANSPORTATION and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RUSH WEBB LAURA REEDY permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 FUNK ROAD, PORT DEPOSIT, MARYLAND SHIRLEY THOMAS / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State APRIL 13 1 🖾 Burial 2 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donattop 5 Other (Specify) 2012 RISING SUN, MARYLAND BROOKVIEW CEMETERY 22. Name and Address of Facilit CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ELLAL FAILLIKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner I mo with HO2 DNA if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) milli executed H0116101 tran gue Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? After this certificate 2 1 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, 1 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No hours after death uneral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year. Emasser. 200 7463 -9-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rolando Najera, MD, 126A East High Street, Elkton, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Abril 1 20 °2 5:30 P M James H. Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Lothian 801 Ben Jones Lane If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Y May 10 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 213-22-0277 **Director** 1**X** M 2 □ F 1918 Maryland 93 Yrs Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland Director Lothian 1 ☐ Yes 2 X No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA with 1 20711 801 Ben Jones Lane and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2X Married þ 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: It Yes, Give Year or Dates 1945 – 46 Specify: **Black** 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Ó 7th Farmer Self Employed injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ည Mamie Wright Benjamin E. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Dorothy M. Jones (Wife) 801 Ben Jones Lane Lothian, Md. 20711 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. Page 1 cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 4-10-12 Lothian, Md. Adams U.M. Church 4 ☐ Donation 5 ☐ Other (Specify) Winame Research ScilitSons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 Zavr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, due to for as a consequence of, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the continuation. Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ned by the atten e detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie BX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selonick MD 31. Date filed (Month gistrar's Signature State 9 2012 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Prove State of Maryland / Department of Health and Mental Hygiene

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janey Sarabeth Louise 201 2230 pri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** Country) MD 1 / 9 / 1 9 4 Days Hours Min. 1 \square M 2 Director 217-76-6770 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material any injury. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert 1 ☐ Yes 2X No Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 50 Appeal Lane Apt.107 20657 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chase Albert Ethel Gough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Janey/son P.O. Box 238, St. Leonard, MD 20685 20a. Method of Disposition
1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Chelt. Vet. Cem. 4/12/2012 Cheltenham, 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, 21. Signature of Funeral Service Ligensee Deade Dares Beach Rd. Prince Fred., MD20678 such as cardiac or respirato arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying shock, or heart failure. List only one cause if Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, MINER the Hospital or Attending Physician: The law requires that the death certificate be executed GERTIFICATION APPROVED BY the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Hinknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by X No Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) director Be examiner? 14 Yes Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work?
1 Yes Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Me: al Examiner: On the basis of camination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

July 19 Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the P only one 29b. Signature

State

Registrar

drw 2

ed cause of death (Item 23a) (Type, P.

32. Registrars

ress of pers

APR

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2012 7 DUANE VINCENT LUCY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 8. Date of Birth (Month, Day, Year) . Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Hours Director 219-05-9816 1 **X** M 2 □ F 92 03/25/1920 MARYLAND Usual Residence of Dece 28a-f show 10a. State 10c. City, Town or Location be notified at Director MD QUEEN ANNE'S GRASONVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? s 23a o. c must b ò Funeral 942 CHESTER RIVER DRIVE UNITED STATES 21638 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working UNITED STATES Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th SENIOR MASTER SERGEANT AIR FORCE Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname ပ HARRY JOSEPH LUCY ADALINE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 STEPHEN LUCY / SON 942 CHESTER RIVER DRIVE, GRASONVILLE, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot CHESAPEAKE CREMATION CENTER 1 Burial 2X Cremation 3 Removal from State 04/10/2012 4 Donation 5 Other (Specify) STEVENSVILLE, MD Signature of Funeral Strvice Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 188 autonsv performed? Yes 2X No certificate l 1 ☐ Yes 2 🛣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State)

11:05 A M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

7,2012

APRIL

1 🗆 Yes 2 🕱 No

Records, P.O. Division of Vital To the Funeral Director: After this To the Hospital or Attending filled in by the

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifier

KERI JACOBS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 BROWN STREET

32. Regiskar's Signature

State Registrar

DHMH 17 Rev 06-2011

🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0071130

CHESTERTOWN, MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death *A* 04:15 M 2. Date of Death Physician/ AVINIA Anonth Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 8. Date of Birth (Month, Day, Year **Funeral** Months 94 **Director** 214-14-6619 1 🗆 M 2 🛛 F Dec. 5,1917 Maryland 28a-f show 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Marvland Washington County Hagerstown 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 20009 Rosebank Way 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Owner Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bertha Grace Shamberger Jacob Lester Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura E. Shindle-daughter 8840 Lemar Rd. Greencastle, PA 17225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other placel 9 Rest Haven Cemetery 4-10-2012 4 Donation 5 Other (Specify) Hagerstown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? the Hospital or Attending Physician: Division of Vital Be Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending thours after death.

uneral Director: Aftely filled in by the fur 2 Accident 3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title ise of death (Item 23a) (Type, Print) IW-1 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Abrill 9, Day 012 Year Physician/ 8:45 а.м John Franklin LEFEVER, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington 16505 Virginia Avenue AptA205 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday, 8. Date of Birth **Funeral** Aug. 12, 1918 Months Hours Maryland 93 217-10-2651 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State Director 1 🗌 Yes 2 🖾 No Williamsport Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21795 U.S.A. 1685 Virginia Avenue Apt A205 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. white If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) painter swords painters Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Adam G. Lefever Stella Renner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Bowman 9430 Stottlemeyer Road, Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salem Refermed Church April 2032 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee Kabull 415 East Wilson Blvd., Hagerstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOVASCULAR DISEASE ATHEROSCLEROTIC disease or condition YEARS Medical resulting in death) Due to (or as a consequence of) Examiner YEARS HYPERTENSION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) at ending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERLIPDEMIA 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s perfor 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 🗌 Yes this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1.X Natural injury 5 Pending Accident 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

JW-4 State

within 2 To the I

Medical

29a. Certifier

(Check

only one 29b. Signaty

12916 CONAMAR DE SUITE 204 HAGERSTOWN, STEVEN BLASH, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MC

Registrar

1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

APRIL 10, 2012

MD 21742

29c. License number

D58810

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Evelyn L. Laidig 9:50 A M 2012 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery Village At Rockville If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Funeral 6. Sex Age (In yrs. last birthday) 8. Date of Birth Nov. 26,1918 1 □ M 2 1 F 204-03-4444 **Director** 93 <u>Pennsylvania</u> Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown yinjury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 💆 Yes 2 🗌 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 U.S.A.9701 Veirs Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify. Specify: White 3

✓ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Hazel Reeder Ross Barkman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Laidig 6574 Dovecote Drive Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Hustontown, PA 4 ☐ Donation 5 ☐ Other (Specify) Hustontown Cemetery 2012 22. Name and Address of Facility Signature of Funeral Service Licensee J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Qnget and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse rue ce of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Respired-tory

Due to (or as a consequence of) that initiated events resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No ę Pregnant at time of death should be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 2 - No certificate 2 🗌 No Yes 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending s after death. 2 Accident M Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Registrar

within 7

29b. Signature a

ares

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Mary	land / Depa	artment of F	Death	Re	g. No.	2 302		
	Physicia Medic		Decedent's Name (First, Middle, La Rosetta	May	Lawt	on		2. Date of Death April	5° 2012 ar	3. Time of Death 2:45 P M		
	Examin		4a. Facility Name (if not institution, given 13136 Manor Driven)			4b. City, Town, or	Location of Death		4c. Carnty of De	#ick		
	Funeral Director		5. Social Security Number 129-20-0123 Usual Residence of Decedent	Sex 7. Age (In 93	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Jan 17,	Year) C	rthplace (State or Foreign ountry) W York		
	aryland a-f shov fied at	ector	10a. State 10b. County Maryland Frederic		c. City, Town or Lo					10d. Inside City Limits X 1 Yes 2 No		
	ith the M 23a or 28 at be not	Funeral Director	10e. Street and Number 13136 Manor Drive			10f. Zip Code	771	10	og. Citizen of What C	country?		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W			
215-0	iin 72 houi ie. han "natu e Medical	Completed by	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o O NOT use retired) Dietary T	during most of work	king	16b. Kind of Busines	,		
Maryland 21215-0036	e filed with ntal Hygien ed other tl : event, the	To Be C	17. Father's Name (First, Middle, Last) James Tenny			Jietaly 1		ne (First, Middle, Ma				
Maryl	2 should bath and Me 27 is mark r traumatic		19a. Informant's Name/Relationship (**					City or Town, State, 2			
Baltimore,	Page 1 and nent of Hea int: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State		osition (Name of matory or other place 11ins Cen	e) n Apri	2012	North Col			
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licer	100e	1	2. Name and Addres	ss of Facility Sta	uffer Fu	neral Homo derick,MD	2PA 21702		
	Physician		23a. Par 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	Dications that caused the one cause on each line. End Stage	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death 2 months		
	Medical Examiner		resulting in death)	Due to (or as a consequence of): Failure to Thrive						2 months		
	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Severe Anemia Megablastic							
09,	certificate be executed nding physician and use as the burial-transit	edical Ex	resulting in death) Last		Due to (or as a consequence of): Diabetic Type II							
89	certif nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tim g Unknown	Fetal death 3	Ectopic pregnand Other (specify)	гу		23d. Date of d	elivery Day Year		
, P.O.	es that th igned by be detar	by	Part II. Other significant conditions		_		ven in Part I.			to the cause of death?		
Division of Vital Records,	I or Attanding Physician: The law requires that the death after death. Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for	Completed	Osteoporosis, Hyrothyroidism, Hypo Albumenia, Renal Insufficiency, Right Hydronephrosis 24a. Was an autopsy performed? 1 Yes 2 No 1 24b. Were prior deat 1 Yes 2 No 1 1									
ital	certifica irector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🙀 No	Hospital:		_ Oth	ace of Death (Chec	ck only one)		es 2 No		
on of V	Attending Physician: The law ar death. ector: After this certificate has by the funeral director, page 2 by the funeral director, page 2.	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye	2 ER/Outpatie 28b. Time of injury	nt 3 □ DOA f 28c. Injun work	4 □ Nursing H y at	ome 5 🗠 Resider 28d. Describe hov	nce 6 Other (Spe v injury occurred	ecify)		
Division	rtal or Atte ins after de al Directo led in by th		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury -	b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Scrity or Town)					Street and Number or Rural Route Number, In, State)		
	To the Hospital or A within 24 hours after To the Funeral Direction To the Funeral Direction of the foundation of the fo	Medical	(Check 2 Medical Exam	ysician: To the best of my niner: On the basis of exam rse Practitioner: To the be	ination and/or inves	tigation, in my opinio	on, death occurred a	at the time, date and	place, and due to the	e cause(s) and manner stated.		
	To t with To tl		29b. Signature and of the of certifier	len /c	sill	29c. License	D54749	29	April 8,	th, Day, Year) 2012		
	6		30 Name and address of person who John Allen Re		(Item 23a) (Type, I 505 Mano	r _{int)} r Park Dr	ive, Roc	kville, N	1D 20853			
ì	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's	- 13	barke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 13022 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Jime of Death 5:15 P Month Physician/ Svea Laughren April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince George's Bowie Health Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Hours 366-14-5156 Director 1 🗆 M 2 🖺 F 92 02/29/1920 Michigan Usual Residence of Decedent or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Bowie MD Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r Funeral 1411 Perrell Lane 20716 within 72 hours after death with 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be fill trent of Health and Mental tant: If item 27 is marked or ပ္ Johanna Carlson Magnus Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan C. Gariazzo/Daughter 15909 Philmont Lane, Bowie, MD 20716 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 04/09/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Septice License 6512 NW Crain Hwy. Bowie Md. 20715 23a. Part 1. Enter the disease, or complications they caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or as a consequence Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant ned by the attenin the past 12 months?

1 Yes 2 No Day Month Year 1 ☐ Yes ∠ ≱ 9 ☐ Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, OST eopenia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? Hospital or Attending Physician: The 2 No Yes 2 1 Yes filled in by the funeral director, Be (25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other (Specify)} \) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pendina s after death. Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier DO058604 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Tunenholz 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13023 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 201 0245 April Elizabeth June Long Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** lalbet Easton Hospit Memoria If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) 6. Sex **Funeral** Hours (Month, Day, Year) 90 186-16-3354 Director 1 □ M 2 🛛 F June 11 1921 Pennsylvania Usual Residence of Dece or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Caroline Goldsboro 10g. Citizen of What Country? o 10e. Street and Numbe 10f. Zip Code must be 23a Funeral 413 Main Street 21636 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian 11 Marital Status th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner i Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Kinnamon Wood Edith Mable Ludlo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Main Street; Goldsboro, Maryland 21636 27 Blanche Bedwell/ sister Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation |Apr 5 2012 Stevensville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 0 Box 160; Greensboro, MD 21639 Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ·V disease or condition resulting in death) a Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed? 1 Yes 2 No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ၉ 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work 1 Natural 5 Pending 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

State Registrar

Medica

29a. Certifier (Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis M. DeShields,

APR 12

. Date filed (Month, Day, Year)

MD

Registrar's Signature

32

DHMH 17 Rev 06-2011

Elizabeth

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0093110

219 S Washington Street; Easton, MD 21601

29d. Date signed (Month, Day, Year)

201

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13024 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 202 Physician/ April Leatherman Louise Katherine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Fahrney Keedy Home Boonsboro Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Oct.11 1 □ M 2 💢 F Day, Ye Maryland **Director** 81 218-24-2112 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Myersville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11522 Harp Hill Road 21773 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Public School 10 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Browning Grossnickle Elise Rebecca Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Phillips/daughter 2727 Flintridge Drive, Myersville, Maryland 21773 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Grossnickle Brethren Apr. 17,2012 Myersville, Maryland 4 Donation 5 Other (Specify) 504 Main Street Myersville, MD 21773 Ricketts Funeral Home Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ trial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** MIG Sequentially list conditions consequence cause. Enter Underlying Cause (Disease or linjury that initiated events Exami and-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown been signed by the should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: eral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending work? within 24 hours after death.

To the Funeral Director: Af 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opa 21740 MURSHED MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 13025 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APELL Physician/ Year 1:00AM 2012 Essie Arbutus Moler Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Boonsboro Reeders Memorial Home Washington Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Numbe **Funeral** Jan. 5, 1935 Days Hours 217-30-5879 77 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Knoxville Washington 1 Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or Funeral USA 21758 938 Valley Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc 1 Never Married 2 X Married Completed by 1 Yes 2 NAME: NOUER, ESSIEBaltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 - Widowed 4 - Divorced Year or Dates ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Optical Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೭ Leoda Pauline Sweeney George Franklin Hoffmaster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 938 Valley Road, Knoxville, MD 21758 Harry Moler - Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brownsville Heights 4-16-2012 Brownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Eackles-Spencer & Norton Funeral Home
Harpers Ferry, WV 25425 MD0970 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCER RT LUNC Physiciani MOUTH disease or condition resulting in death) MAL Medical Due to (or as a consequence of) Examiner MPHOWE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes 2 ¼ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERTEDSION HY PERLIPIDEMIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 11, 2012 Cern Hernandle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 2174

DHMH 17 Rev 7/2009

State Registrar

Mover

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State of Maryland / Department /	artment of Health and N tificate of Death		ene 2012	13026
Ph	ysicia	n/	Decedent's Name (First, Middle, Last) FRANKLIN WAYNE MARTZ		2. Date of Death	0 ² / ₂ 20 ² / ₁ 2	3. Time of Death 11:34 AM
	Medic xamin		4a. Facility Name (if not institution, give street and number) FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK		4c. County of Death	
	neral ector		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Feb. 8,	9. Birth Cour 1940 Mar	place (State or Foreign ntry) y Land
yland	f show ed at	ctor	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 □ No
the Mar	a or 28a- be notifi	. <u>≒</u> L	Maryland Frederick Frederich One Street and Number 217 East Second Street	10f. Zip Code 21701	10	g. Citizen of What Cou U.S.A.	
land Z1Z13-UU30 be filed within 72 hours after death with the Maryland ental Hygiene.	iner must	y Funer		Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri Black, White,	
Ours after	atural", c cal Exam	eted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	Yes 2 X No Specify:	1.00	Tapsony.	nite
Z1Z13-UU30 within 72 hours after giene.	r than "na the Medio	Completed	(Specify only highest grade completed) (Give Figure 14-4 or 5+)	ent's osdan occupation ind of work done during most of work DNOT use retired) Drney	ing	6b. Kind of Business/Ii Law	noustry
yland All I I I I I I I I I I I I I I I I I I	rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Franklin Augustus Martz	18. Mother's Nam The Im	e (First, Middle, Ma a Linton	iden Sumame)	
Maryland	27 is ma er traumal		19a. Informant's Name/Relationship (Type, Print) Mrs. Carol K. Martz, wife 217	g Address (Street and Number or Rure Last Second Stree	al Route Number, C t, Freder	ity or Town, State, Zio ICK, MD 21	701
baitimore, Maryland permit. Page 1 and 2 should be find Department of Health and Mental	ant: If item ury or othe		20a. Method of Disposition 1 \(\begin{align*} \text{Burial 2} \subseteq \text{Cremation 3} \subseteq \text{Removal from State} \\ 4 \subseteq \text{Donation 5} \subseteq \text{Other (Specify)} \end{align*} 20b. Place of Disposition cemetery, great the property of the control of the contr	sition (Name of natory or other place) et Cemetery Apr.	14, 2012	Oc. Location - City or T Prederic	own, State
balt permit. Depart	Import any inji once,		21. Signature of Funezal Service Licensee M00255	Keeneydant Basfo 106 East Church	rd PA Fur St., Fred	neral Home derick, MD	21701
<i>F</i>	irian edical miner		23a, Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		or respiratory arrest		Approximate Interval Between Onset and Death
ecuted	and al-transit	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	-			
ate be ex	onysician the buris	dical	d				
DIVISION OF VITAL RECORDS, P.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	the attending p	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
S, P.O.	signed by Id be detar	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to	the cause of death?
VITAI KECORUS, NSICIAN: The law requires	are nas beer page 2 shou	Completed			24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
VITAI ysician:	s certific director,		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Chec		ce 6 ☐ Other (Specia	fv)
on ot ading Ph	: Arrer m e funeral		27. Manner of Deat 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVISION tal or Attendii	al Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streething building, etc. (Specify)	eet, factory, office			
the Hospit	the Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the configuration of the configuration of the properties of the properties of the configuration of the c	tigation, in my opinion, death occurred a	t the time, date and	place, and due to the c	ause(s) and manner stated.
P With	COM		29b. Signature and title of certifier	29c. License number D 4795 (C	d. Date signed (Month)	2012
	9			occ House-Ave	FREDE	RICK, MI	721701.
R	Stat egistra		31. Date filed (Month, Day, Year) APR 10 2012 32. Registrar's Signature	barks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** reter 45pm mcDermott /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care Chesapeake Arnold Anne Arundel 7. Age (In yrs. last birthday) if Under 1 Year | if Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Days 1⊠M 2□F 076-12-3081 90 Director Oct. 6, 1921 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show odical Examiner must be notified at Maryland Anne Arundel Arnold 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with in and Mental Hygiene.
Is marked other than "natural", or items 23a or 1270 Caddie Drive 21012 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1∑Xes 2 ☐ No If Yes, Give 1.17.7 — T 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIIo Specify: ģ White 3 Widowed 4 Divorced Year or Dates: WW II Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Advertising Sales Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter A. McDermott Frances Heenan P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Joan McDermott/wife 1270 Caddie Drive Arnold, Maryland tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I permit. Pages Department of I Important: If ite any injury or o 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State Baltimore Crematory 4/9/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Tuneral/Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home vade 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final ascular. **Fhysician** 7 days disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performs 1 ☐ Yes 2 No Division or Vital 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the

31. Date filed (Month, Day, Year) APR 1 0 2012

29b. Signature and title of certifier

AVIATION BIVA Suite B. Glen Burnit MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

park

29c. License number

29d. Date signed (Month, Day, Year)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State of	Marylan	d / Depa <i>Cei</i>	artment of <i>tificate of</i>	Death Death	n and IV 1		giene Reg. No.	201	2	3028
Н	Physicia	n/	1. Decedent's Name (First,								2. Date of De Month	ath /3/20	12 Year	3. Tim	e of Death
	Medic Examin		Mary Jane MacDonald 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea) IVI			
فمر			1208 Odenton Rd. Ode										nne Ar		
	Funeral Director		5. Social Security Number 378–24–1247	6. Sex	х 7 ⊐м 2 Х Т	Age (In yrs. la	7	If Under 1 Year Months Days				th y, Year)		thplace (Sta ountry)	te or Foreign
	į		Usual Residence of Dece	dent	J M ZALAF		Yrs.				1/18/19	925	I	N	
	yland -f sho ed at	ctor	10a. State 10b. C		1 1	10c. City	y, Town or Lo							1	e City Limits Yes 2***No
	ne Mar or 28a notifi	Director	MD At	nne Ar	undel			Odenton 10f. Zip Code				10g. Citiz	zen of What C		163 2 1110
	with the s 23a c	Funeral I	1208 Odento	on Rd.					211	13	1		USA		
	death items ner m	Fun	11. Marital Status		12. Was Decede Armed Forc	es?	3. 13.	Was Decedent of f Yes, specify Cu	Hispanic (ban, Mexic	Origin? (Spe can, Puerto I	cify Yes or No- Rican, etc.)	1	14. Race - Am Black, Whi		,
036	is filed within 72 hours after death with the Maryland tal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 3 3 Widowed 4 Div		1 Yes 2 If Yes, Give Year or Date			1 ☐ Yes X X N	lo Spec	ify:		5	Specify:	White	<u> </u>
2 C	2 houn "natur dical	Completed		ecedent's Ed y highest grad			16a. Dece	dent's Usual Occi	upation e during m	ost of worki	ng	16b. Kir	nd of Business	/Industry	
121	ithin 7; ene. • than he Me	Som	Elementary/Secondary (0-12)	College (1-4	or 5+)	Ìife. D	O NOT use retire Homemak	d)				Own H	0.00	
Maryland 21215-0036	iled withir I Hygiene other the rent, the	Be	17. Father's Name (First, Mi	iddle, Last)				пошешак		other's Name	e (First, Middle,	Maiden S		ome	
ylar		입	Edwin South	ard					Jar	ne Hut	chison				
Mar	2 should Ith and Ma 27 is mar traumati		19a. Informant's Name/Rel					ng Address (Stree				-	Town, State, Z	ip Code)	
	and Hea em the		Bruce MacDor 20a. Method of Disposition		Son		lace of Dispo	Napa Ct			MD ZI		cation - City o	r Town, State	9
E E			1 ☐ Burial ※ Cren 4 ☐ Donation 5 ☐ C	nation 3 🗆 Other (Specify	Removal from S	late		natory or other parto		4/7/	2012	Glen	n Burni	e. MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Se	ervice License	mlade		22	2. Name and Add	ress of Fa	^{cility} Har		Funer	al Hom	e, P. <i>A</i>	Α.
H			23a. Part 7. Enter the dises						_				<u> 2170</u>	Approxi	mate Between
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J	Medical Examiner		resulting in death)	ſ		as a consequ	ience of):	Ends	Dia.					Moiny	year
		ner	Sequentially list conditions if any, leading to immediat	e J	Due to (or	as a consequ	uence of)							M	of the same
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C	as a consequ		M						1º barry	Years
	cate be executed physician and s the burial-transit	cal E	resulting in death) Last	L	Due to (or			idism						Meson	your.
3760	ficate figures groups	Nedical			d										
89 ×	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregna in the past 12 months'	111		rth 2 🗌 Feta	al death 3	Ectopic pregna				2	23d. Date of d	elivery Day	Year
Box	ie deal	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4 ∐ Pregna 9 ☐ Unkno	ant at time of c	death 5 L	Other (specify)					WOTET	Day	1681
P.O.	that the ned by the e detache	by Pr	Part II. Other significant c	onditions co	ntributing to dea	th but not res	ulting in the u	underlying cause	given in Pa	art I.			se contribute t		
	quires en sign ould b										1 🗆	Yes 2	No 3□	Probably 4	Unknown
Records,	The law requires ate has been sign page 2 should be	Completed									24a. Was auto		24b. Were a prior to death?	completion	
He He		e Col	25. Was case referred to m	edical [26	Place of F	Death (Check	1 \(\text{Yes}	2 1100		es 2 🗆 No	
Vital	ysícia s certi direct	To Be	examiner? 1 Yes 2 No	- 19	Hospital:	patient 2 🗌	ER/Outpatie		thor	, , , , , , , , , , , , , , , , , , , ,	me 5 Resi	dence 6	Other (Spe	cify)	
ot	Attending Physician: If death. ector: After this certific by the funeral director,		27. Manner of Death	Pending	28a. Date of (Month	injury , Day, Year)	28b. Time o injury	W	ork?		28d. Describe	how injury	occurred		
Sion	ttendi death. stor: A y the fi	Certificate:	2 Accident 3 Suicide 6	Investigation Could not be		f Injuny - At ho	ome farm str	M 1 reet, factory, offic	Yes 2		28f. Location (Street and	Number or R	ural Route N	umber
Division of	pital or Attendours after deatleral Director.		4 ∐ Homicide	determined		, etc. (Specify		cot, factory, offic	0		City or To			ara, riodio ri	arribot,
_	To the Hospital or Attending Phys within 24 hours after death. To the Euneral Director, After this completely filled in by the funeral di	Medical	(Check 2 In Me	dical Examir	ner: On the basis	of examination	n and/or inves	occurred at the ti stigation, in my op , death occurred a	inion, death	h occurred at	the time, date	and place,	and due to the	e cause(s) and	i manner stated.
	To the within To the comp	2	, , ,		flen		ny knowloage	29c. Lice	nse numbe	er			e signed (Mon)
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	Star	te	Mirza Nusaii 31. Date filed (Month, Day	ree I	00/ Cro	gistrar's Signa	ture	back 1 Cr	OITOI	n, MD	<u> </u>				-
	Registra		APR	1020	114 /	new	p. 19	ALL							

Amend Items State of Maryland / Department of Health and Mental Hygiene 20 | 2 | 2 | 2 | Amend Items 25,27,28a-f per me, 9927,05/11/2012dhb Reg. No. 13029 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McClendon Dorothy Louise April 6. 2012 4:55AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Home For Hospice Denton Caroline Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 G 09/17/1936 75 Director 577-48-6663 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Caroline Ridgely 1 🗆 Yes 2 🛣 No MD 10e. Street and Number ms 23a or must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 14979 Cherry Lane 21660 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. 1 Never Married 2 Married ò ģ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 'natural", Completed 3 XWidowed 4 ☐ Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pharmaceuticals 4 1 2 1 Data entry personnel event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve ဂ္ဂ Vernon Franklin Baxley Mary Margaret Winter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Burneston / daughter 1479 Cherry Lane, Ridgely, MD 21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 4/6/2012 Dover, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility low Moore Funeral Home, P.A., 12 S. 2nd St., Denton, MD 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Pnysician/ Onset and Death METAS 1411 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events tran and CERTIFICATIO Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical certificate be Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ŏ Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, SUBOURGE HEMATOMA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. A Unknown EPIDURAL HEMTATOMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate Yes 2 No 1 Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other:
4 \(\sum \text{Nursing Home} \) 5 \(\sum \text{Residence} \) 6 \(\sum \text{Other} \) (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28b. Time of Found Poly Year Junknown Found Poly Year Junknown Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending T Natural 2 X Accident 5 Pending Division work? 1 Yes 2 No Subject fell downstairs ours after death leral Director: A filled in by the f Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 14979 Cherry Lane determined Garage Denton, MD 24 hours a Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 00052509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAMES 609 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

A55

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 G. Malone 07:15 A M Anna Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth
(Month, Day, Year)

7 h 16,1918 Country Home Assisted Living Harwood Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 👿 Months Days Hours **Director** 577-28-2740 94 Washington DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location . Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Dunkirk 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 John's Lane 20754 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. ral", or iter Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo "natural", Completed White 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Federal Government other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Fortunato Gioffre Maria Briganti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Josephine Boertlein- Sister 6336 John's Lane, Dunkirk, MD item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 04/12/2012 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Lie 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on e Immediate Cause (Final Inset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 2 100 Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie dRW 4

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 13031 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Beatrice R. Marshall 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cumberland ic. County of Death **Examiner** Western MD Regional Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 220-10-9193 Director 1 □ M 2 🔀 F 06-03-1916 Maryland Usual Residence of Decedent 28a-f show 10a. State er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MD Allegany 1 Yes 2 No Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 U.S.A. 100 Honevsuckle Lane Apt 117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Taxi Cab Owner Taxi other injury or other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F 2 Estella Maude Trimble Ryan Charles W. Ryan and 2 should b Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 17215 Mt. Savage RD NW Frostburg, MD 21532 Frances Ryan POA, cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Frostburg MEm Park 04-13-2012 Frostburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility sowers Funeral Home. any 4190 Sower3 mo057/7 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each inex Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4- Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ACEK 24a. Was an 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Records, To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics **Division of Vital** completely

Baltimore,

Box 68760

State Registrar (Check only one)

30. Name and address of

MD 1221 Nationa 31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

La Vale MD 2/502

29d. Date signed (Month. Dav. Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13032 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 4, 2012 Day 5:00 a м Freddie Jean McClurg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Sandy Point Group Home Prince Frederick 8. Date of Birth . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days January 15, 1934 1 🗆 M 2 🗶 Hours Yrs Director 235-95-1650 78 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified 1 Yes 2 No MD Prince Frederick Calvert 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? rms 23a or Funeral 6185 Sandy Point Road 20678 USA death \ Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian "natural", or iter idical Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) d other than " life. DO NOT use retired) Ith and Mental Hygiene.

27 is marked other than r traumatic event, the Man Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Someone Else's Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည George Wallace McClurg Lillian Gertrude Walden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8280 SW 24th Street Unit 7105 North Lauderdale, FL 33068 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Gerald McClurg - brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory April 4, 2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. Signature of Funeral Service Lic 1451 Dares Beach Rd. Prince Frederick, MD 20678 $rac{4}{3}$. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 No Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After injury 1 Natural 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

32. Registrar filed (Month

determined

4 Homicide

only one)

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_		1 - State of Maryland / Depar State Registrar Certif	tment of Health and Meificate of Death	ental Hygie	0010 10000
T	Physicia	in/	Decedent's Name (First, Middle, Last) -		2. Date of Death	Day, Year. 3. Time of Death
m of	Medic	al	Scott Edward Noll 4a. Facility Name (if not institution, give street and number)	Ab. City Town or Leasting of Death	A0771	Day 12 2012 4:41 M
Ĵ	Examin	er	Meritus Medical Center	4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington
4	Funeral Director			If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea 10/30/196	9 Birthplace (State or Foreign
	land show dat	ţo		tion		10d. Inside City Limits
	Mary 28a-f lotifie	Director	MD Washington Hagerston	wn		1 ☐ Yes 2 📈 No
	ith the 23a or st be r			10f. Zip Code		. Citizen of What Country?
	eath w	Funeral	13926 Pontius Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21740 as Decedent of Hispanic Origin? (Speci	ify Yes or No-	J. S. A. 14. Race - American Indian,
9800	ırs after de ural", or it Il Examine	by	1 Never Married 2 Married 1 See 2 No	∕es, specify Cuban, Mexican, Puèrto Ri ☑ Yes 2 No S <i>pecify:</i>	ican, etc.)	Black, White, etc. Specify: White
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kin life. DO!) Elementary/Secondary (0-12) College (1-4 or 5+) life. DO!	nt's Usual Occupation I'd of work done during most of working NOT use retired)	7 161	o. Kind of Business/Industry
d 2	led wi Hygid other ent, t	Be	17. Father's Name (First, Middle, Last)	uce Manager	First, Middle, Maid	Grocery Jen Surname)
ylar	should be file and Mental 7 is marked or raumatic eve	입	William M. Noll	Barbara	a K. Carr	nig
	nd 2 shoul saith and n 27 is m er trauma		The contract of the contract o	Address (Street and Number or Rural F Mercersburg Rd.,		
Baltimore,	permit. Page 1 ar Department of He Important: If iten any Injury or oth		Table Surface 2 El Grennation of El Frennoval Holli State	ion (Name of Da tory or other place) n Mem. Park 4/17/2		c. Location - City or Town, State
Balt	permit. Departr Import. any Inj		21. Signature of Funeral Septice Licenses 22. N	Name and Address of Facility Rest	t Haven H	Guneral Chapel
window	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Approximate Interval Between Onset and Death
	Medical Examiner		Due to (or as a consequence of):	Ċ		
	ed nsit	Examiner	Sequentially list conditions, b.	alnutrition		
	cate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	W. C. W. C.		
09/	physic the b	edic	d			
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Tuneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ E 4 ☐ Pregnant at time of death 5 ☐ C	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	requires that the been signed by should be deta	ed by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		co use contribute to the cause of death?
Division of Vital Records,	sician: The law red certificate has bee lirector, page 2 sho	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
ta	ding Physician: The la h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check or		100 22110
Ξ	Physi this c	은	1 Ves 2 Let No 1 Inpatient 2 PER/Outpatient 27. Manny of Death 28a. Date of injury 28b. Time of			6 Other (Specify)
0 U	rding th. : After e fune	cate	1 Matural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	28c. Injury at work? M 1 Yes 2 No	d. Describe how in	jury occurred
)ivisio	Plospital or Attending Is 24 hours after death. Funeral Director: After etely filled in by the funer	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)		If. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death occ	ition, in my opinion, death occurred at thi	ie time, date and pla	ace, and due to the cause(s) and manner stated.
	To the To the Comple	- 1	29b. Signature and title of certifier Turk	29c. License number D 0 6 e 3 9 6		Date signed (Month, Day, Year)
	5 m		30. Name and address of person who completed cause of death (Item 23a) (Type, Print FARI)	,	down	mo 21740
Ē	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1117		

/Medical Examiner **Funeral** Director show notified 28a-f within 72 hours after death with ral", or Items 23a or Examiner must be Baltimore, Maryland 21215-0036 "natural",

13034 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** William A. Noble April 7:40 P M 07. 2012 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Caroline Envoy of Denton Denton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours **X**□M 2□F 20, 1927 217-36-0664 Aug. Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Federalsburg Director MD Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 21632 4939 Preston Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Grain Farmer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Magdaline Lowe Roland Kemp Noble 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25829 Three Bridges Rd., Federalsburg, MD 21632 Beverly J. Matthews/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Hill Crest Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or oti 1 Purial 2 □ Cremation 3 □ Removal from State 04/14/12 Federalsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Framptom Funeral Home, P.A. <u>216 N. Main St., Federalsburg, MD</u> 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MO10 UKSCULIR disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 ☐ No detached 1 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ber 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**51** No 2 No 1 ☐ Yes 1∐ Yes Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 1 🗌 Yes filled in by the funeral 28a. Date of Injury 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or the Funeral Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 7 29d. Date signed (Month, Day, Year) 2 053094 BLOOMINGS AN A

State Registrar Year

APR 11

DHMH 17 Rev 1/2001

163

Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 578-92-8238 Director 1 X M 2 □ F 48 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location be notified at Director MD Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code ms 23a must be Funeral 4835 Cordell Ave. #809 20814 items "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force 0.10 þ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates than "natura he Medical E 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Clerical other Be filed all Hyg 17. Father's Name (First, Middle, Last) marked ပ John Lee Poore and 2 should b Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) John Peter Poore/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o cemetery, crematory or other place 1 Durial 2 X Cremation 3 Demoval from State 4 Donation 5 Other (Specify) 21. Signature of Fund Service 10 MO1315 Immediate Cause (Final disease or condition Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease of injurthat initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death the by deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by acute renal failure, pneumothorax, acidosis Completed has page 2 25. Was case referred to medical Hospital or Attending Physician: Be examiner? CORE, DAVID Hospital 1 Tyes 2X No Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: within 24 hours after death. To the Funeral Director: After to completely filled in by the funer 1 Natural 5 Pending 2 Accident

1 - For State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 David Andrew April 5, Poore 8:04 \mathbf{P} M 4b. City. Town, or Location of Death 4c. County of Death Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Aug. 15,1963 Maryland 10d. Inside City Limits 1 X Yes 2 □ No 10a. Citizen of What Country? U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Insurance 18. Mother's Name (First, Middle, Maiden Surname) Nancy Lorraine Moss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 Eastpine Court, Columbia, SC 29212 20c. Location - City or Town, State Metropolitan Crematory 4/9/2012 Alexandria, VA 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death week 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 X No 2 No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number D0060117 April 6, 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park, MD 8600 Old Georgetown Road Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 1 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

13035

Registrar DHMH 17 Rev 06-2011

State

To the !

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 13036 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04/05/2012 MICHAEL BRUCE PIPKIN JR. 5:15 P^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL 2047 HAVERFORD DRIVE CROWNSVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) Director 213-92-6730 1 🛛 M 2 🗆 F 50 07/19/1961 MARYLAND Usual Residence of Deced 28a-f shov ural", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2X No MARYLAND ANNE ARUNDEL CROWNSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2047 HAVERFORD DRIVE 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 \square Never Married 2 $\overline{\mathbf{X}}$ Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 PHYSICIAN HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ MICHAEL PIPKIN BETTY JORDAN and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau PAMELA LENT PIPKIN/ WIFE 2047 HAVERFORD DRIVE CROWNSVILLE, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 04/09/2012 STEVENSVILLE, MARYLAND ame and Address of Facility LASTING TRIBUTES BY FELLOWS, FENBEIN & NEWNAM CREMATION & FUNERAL CARE P.A BESTGATE ROAD ANNAPOLIS, MD 21401 22 Part 1. Enter the dispesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ esophageal Cancer disease or condition 6 mondhs Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) -transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown npletely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 2 MNo 2 1 N 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No ၉ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural injury 5 Pending work? 2 No __ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0059793 6,2012 mi 41410 (0. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID E.

,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 13037 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Robert Clyde Palmer 2012 a M 4:35 Apri Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Y Oct. 2, Social Security Number 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1<u>947</u> Months Days Hours 1 🛛 M 2 🗆 F 215-48-2262 Mary land Director Jsual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Ceci1 Colora 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21917 U.S.A. 133 Barnes Corner Road 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 XMarried Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: 3 Widowed 4 Divorced White Year or Dates. Vietnam ige 1 and 2 should be filed within 72 hours nt of Health and Mental Hygiene, it if item 27 is marked other than "nature or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Chrysler Corporation College (1-4 or 5+)
One Year Elementary/Seconday (0-12) Repairman Newark, Delaware Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ethel F. Nourse John F. Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Judy A. Palmer 133 Barnes Corner Road, Colora, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State West Chester, R.A.Ferris & Co., Inc. 04/12/12 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sici_n/ unresceptive Sirvamos Cell Medical resulting in death) Due to (or as a consequence of) Examiner 9 lous praciller Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or iinjury that initiated events resulting in death) Last neulth Carr associated and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part <mark>I</mark>. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural work? ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖳 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 MO DD064015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14+1VA Bel Air MO 500

Registrar

31. Date filed (Month, Day, Year)

7

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 William 3:43 PM Paxton, Jr. Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 267 Greenridge Drive Dunkirk Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Dec. 15 1 X M 2 - F Hours 579-40-8939 .1932 Washington DC **Director** 79 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Dunkirk 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 267 Greenridge Drive United States 20754 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1951
If Yes, Give Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Specify: Completed 1965 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Specialist NASA permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Paxton, Sr. Gladys Whitlock . Page 1 and 2 should b thent of Health and Mer tant: If item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Paxton - Wife 267 Greenridge Drive, Dunkirk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State MD Veteran's Cemetery Other (Specify) 2012 Cheltenham, Maryland 22. Name and Address of Facility Signature of Fu rice Licensee Lee Funeral Home Calvet, P.A. 8200 Jennifer Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nown S Immediate Cause (Final Physician/ disease or condition resulting in death) 10 Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes **Division of Vital** Be Was case referred to medical 26. Place of Death (Check only one) Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DOD5906 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick drw 5 110 Hospital State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Day William C. 2012 Phipps 8:02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center <u>Annapolis</u> <u>Anne Arundel</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Hours 212-42-5075 1 🛛 M 2 🗆 F **Director** 68 02-05-1944 Maryland Usual Residence of Deced ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Shady Side MDAnne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1223 Linton Lane 20764 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 1 any injury or other traumatic event, the Medical Examone. 1 Yes 2 X No Specify Specify: Completed 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Chester Phipps Blanche Eleanor Linton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Phipps, Spouse 1223 Linton Lane, Shady Side, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 4-9-2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause ou Immediate Cause (Final Physician/ teriosclerotic disease or condition resulting in death) Medical Ne to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death g Unknown Unknown s been signed by the should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2.5 autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No မြ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, cause of death (Item 23a) (Type, Print) e and address of person who comp

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

Medical

29a. Certifier

(Check

32. Registrar's Signature filed (Month, Day, Year) 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\,2\,0\,$ | $\,2\,$ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death off en Berger Physician/ 10:225 2012 Medical 4a. Facility Name (if not institution, give street and number)

Mortis Medicol Center Examiner 4b. City, Town, or Location of Death 4c. County of Death HADRISTOWN Woshino If Under 1, Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Sócial Security Number 7. Age (In yrs. last birthday) Hours 220-30-9942 1 🖁 M 2 🗆 F **Director** 79 1932 09 17 Hagerstown, MD 28a-f show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Franklin Waynesboro PA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17268 US 11800 Orchard Lane filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 X Married δ Yes, Give Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the elevator manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lavinia Jackson John R. Poffenberger permit. Page 1 and 2 should Department of Health and M Important. If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn D. Poffenberger Waynesboro, PA 17268 11800 Orchard lane 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cumberland Valley Crem. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/2012 Waynesboro, PA 17268 Grove-Bowersox Funeral Home, Inc 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 50 S. Broad St. Waynesboro, PA 17268 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part 1 Approximate shock or heart faili Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown ed by the a detached f 9 Unknown P.O. Part II. **Other significant conditions c**ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy death? eral Director: After this certificate filled in by the funeral director, pag 1 Yes 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes Other: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Acciden work? 1 🔲 Yes 2 🗀 No death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hours after City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce License number Name and address of person who completed cause of death (Item 23a) (Type, Print) DID State Registrar

Box 68760 P.0. Records, To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division of Vital

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D0025344 April 10, 2012 on who completed cause of death (Item 23a) (Type, Print) Ginsberg, 3905 National Drive, #220, Burtonsville, MD 20866 MD

11:10 am

9. Birthplace (State or Foreign

MD

Approximate Interval Between Onset and Death

mos.

Year

Day

2 🗆 No

10d. Inside City Limits

1 Yes 2 No

KY

State Registrar

Medical

29a. Certifier (Check only one 29b. Signature and title of certif

30. Name and address of per

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner erda 1976 If Under 1 If Under 24 Hrs 8. Date of Birth September 9. Birthplace (State or Foreign Social Security Number 223 - 91 - 6 **Funeral** Hours Min. Months Days 1 🔣 M 2 🗆 35 Yrs. Director 61 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State Director 1 X Yes 2 No 10f. Zip Code Citizen of What Country? 10e. Street and Numbe Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status "natural", or iter edical Examiner Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ¥ Yes 2 □ No Specify: C 3 Divorced 4 Divorced atino Palvadoria Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) eaning. oring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License oux DC 200/1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ears Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) ician and e burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death ed by the detached 9 Unknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate has 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{R}\) Residence 6 \(\sum \) Other (Specify) 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 L Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗆 No 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🛮 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Signature and ANP-BC 00093

State Registrar Name and addr

9206

of person who completed cause of death (Item 23a) (Type, Print)

2012

Registrar's Sigr

			For State	State of M	aryland /					Mental Hy	giene	201	2	13043
		_	Registrar 1. Decedent's Name (First, Middle	. Last)	Certificate of Death						Reg. No. 2 0 1 2 2 Date of Death 3 Time of Death			
	Physicia		Donna	Louise		Rai	hh			Manada Davi Vi				3. Time of Death A
1	Medic Examin		4a. Facility Name (if not institution			Ka		own, or Loca	ation of Death	n-(b)	4c.	County of I	Death	0.00
- 0			Meritus Med	ical Center				Hagers				Washi	ngto	on
	Funeral Director		5. Social Security Number 320-24-5283	6. Sex 7. Ag	je (In yrs. last t		If Under 1 Months	1 Year If U Days Ho	urs Min.	8. Date of Birt (Month, Da		g	Birthpla Country	ce (State or Foreign
			Usual Residence of Decedent	1 L M 2 M F	89	Yrs.				Oct. 1	2,19	22	I11	inois
	land show	to	10a. State 10b. County		10c. City, To	own or Loc	ation							d. Inside City Limits
	Mary 28a-1 otifie	Funeral Director		shington	Hag	gerst	own							1 🗆 Yes 2 🗓 No
	th the	al D	10e. Street and Number				10f. Zip (Code			10g. Citiz	zen of Wha	t Country	y?
	ath wi	nuel	10719 Oak Fore	st Drive	Ever in LLC	10 1/	Van Denede	2174		anifu Van av Na			J.S.,	
ပ္ပ	or ite	by F	1 Never Married 2 Mar	Armed Forces?		lo. v	Yes, specif	fy Cuban, Me	exican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, V	American Vhite, etc	
03	ırs aft ıral", I Exal	ed	3 X Widowed 4 □ Divorced			1	☐ Yes 2	X No Sp	ecify:		3	Specify:	Whi	te
21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Deceder (Specify only highs	nt's Education est grade completed)	1			Occupation done during	most of work	ina	16b. Kir	nd of Busin	ess/Indu	stry
121	thin 7	[등	Elementary/Secondary (0-12)	College (1-4 or 5	ō+)	Ìife. DC	O NOT use r	/						
	Hygie Other ent, t	Be (12 17. Father's Name (First, Middle, L	_ast)			Hon	nemake		e (First, Middle,	Maiden S		Home	e
lan	be fil lental rked tic ev	욘	Robert J. And	rews						E. Mor		arriarrio)		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh		1	19b. Mailin	g Address (-		al Route Number		Town, State	, Zip Co	de)
	ge 1 and 2 s t of Health If item 27 i or other tra		Jan R. Rabb/S	on		10719	9 0ak	Fores	t Driv	e, Hage	rstov	vn Mai	ryla:	nd 21740
Baltimore,	ye 1 an it of Ho if iter or oth		20a. Method of Disposition 1 Durial 2 X Cremation	3 Removal from State		e of Dispos etery, crem	sition (Name natory or oth	e of ner place)		Date	20c. Loc	cation - Cit	y or Tow	n, State
tim	t. Pag tmen tant: ijury		4 Donation 5 Other (S	Specify)	1	ıffer	Crema	atory	04/	10/2012	Fre	ederi	ck, I	Maryland
Bal	permil Depar Impor any in		21. Signature of Funeral Service L	icensee				Address of F	Da					Home, P.A.
		\vdash	23a. Part 1. Enter the disease, or	complications that caused	the death D		06 01	d Nati	onal P	ike, Bo	onsb	oro,		land 21713
	Physician/		shock, or heart failure. List o Immediate Cause (Final	nly one cause on each line).	THE CITE	, and mode	or dynig, odd	iii as cararao (or respiratory arr	001,		Ir	pproximate nterval Between Inset and De <i>a</i> th
	Medical		disease or condition resulting in death)	a. Due to (or as a	a consequence									
	Examiner		Constant that are the	· Mac		0.000)							
	- ±	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequenc	ce of):								
	and trans	хап	Cause (Disease or injury that initiated events	c	0.0000000000000000000000000000000000000	20.0%			***					
_	ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a	a consequenc	e oi):								
760				d										
289	eath certifica attending p d for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1 =				2	3d. Date of	f delivery	
Вох	e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pre Other (spec					Month	Da	ay Year
0.	hat the dea ed by the a detached f	Phy	9 🗆 Unknown											
	ires that signed I d be del	by	Part II. Other significant condition	ns contributing to death b	ut not resultin	ig in the ur	iderlying ca	use given in	Part I.					cause of death?
rds	require been si should	etec												oly 4 🗆 Unknown
900	has has	Completed								24a. Was a autop			to comp	findings available letion of cause of
Ä	ician: The la certificate ha rector, page		25. Was case referred to medical					50 DI 1	B 11 (2)	1 Tes	2 No		Yes 2	K No
/ita	ysician: s certific director,	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/	Outpation	+ 2 \(\sum_{\text{DO}}\)	Other:	Death (Check	ome 5 Resid	0[7 OHb - 11 /0	/6.)	
of Vital Records,	r Attending Physter death. rector: After this by the funeral di		27. Manner of Death	28a. Date of injur	ry 28b	b. Time of		c. Injury at		28d. Describe h			pecity)	
on	endin eath. or: Aft the fur	fica	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident Investig	gation	, rear)	injury	М	work? 1 Yes	2 🗆 No					
Division	or Att fter de lirecto in by t	Certificate:	3 ☐ Suicide 6 ☐ Could (4 ☐ Homicide determ		iry - At home, Specify)	, farm, stre	et, factory, o	office		28f. Location (S City or Tow		Number or	Rural Ro	oute Number,
Ö	pital o		170	Dharisian Tabbabas of		1 1	4 60							
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral process.	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of ex Nurse Practitioner: To the	xamination and	id/or investi-	gation, in my	y opinion, dea	ath occurred at	the time, date ar	nd place, a	and due to t	the cause	(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier	Noise Practitioner. To the	s best of my kr	nowleage,	29c. I	License numb	e, date and pia per	ace, and due to tr	e cause(s 29d. Date	s) and mann signed (Mo	er as stat onth, Day	ed. , Year)
			▶ Amst	er M	D			D7	002	1	41	9/2	0/2	
			30. Name and address of person v		eath (Item 23a	a) (Type, Pr	rint)	1		,				21742
JI	1-10		Housia Ams		1111	6 1	med	real	- Com	Pus Re	1. H	ages	stow	MMD
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	2012 32. P gistra	ar's Signature	1 6	MA							21742 MMD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 13044 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day April 19, 2012 **Medical Examiner** 0738 hrs WILLIAM EARL REED 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16327 Old National Pike Hagerstown Washington 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Jan∪ary 23,195**4** 218-62-8055 1 X M 2 F 58 country) W. Va. Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 123a or 28a-f show e notified at once. 1 Yes 2 X No or 28a-f show Maryland Washington Hagerstown Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho of the r trannatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16327 National Pike 21740 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Yes If Yes, Giva Year 1973-1977 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Tow Truck Driver/Mechanic Towing Business 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William Earl Reed Sr. Delores Irene Albanese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16327 National Pike, Hagerstown, Md. 21740 Debra A. Reed Wife 20a. Method of Disposition

1 Surial 2 Cremation 3 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Removal from State Greenlawn Memorial Pk Williamsport, Maryland 04-24-12 4 Donation 5 Other Specify ²² Name and Address of Facility
Andrew K. Coffman Funeral Home,
40 East Antietam Street, Hagers 21. Signature of Funeral Service Licens Inc. roll Hagerstown 21740 Md. **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and \/Medical Death Coronary Thrombosis Immediate Cause (Final disease £xaminer or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit executed /sician/Medical x AMENDED 23a-b,pt.II,27,per me,g928 6-8-12 sm #13a noted,per me,g928 6-15-12 sm X UNPENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Hypercholesterolemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? page 1 🗸 Yes 1 ✔ Yes 2 No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 2 this 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: 5 Pending 1 Yes 2 No death. 2 Accident Investigation 124 hours after d e Funeral Direct 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (P) O.C.M.E. April 20, 2012 Ple 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James Knipp Rice 2012 8:35P April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery MedStar Montgomery Medical Center Olney If Under 24 Hrs. If Under 1 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year) **Director** 203-12-5312 1 ☑ M 2 □ F 89 Mar. 12 1923 Pennsylvania Usual Residence of Deceder 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at rector 1 X Yes 2 No Sandy Spring MD Montgomery Ö 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be r 1708 Hickory Knoll Road 20860 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian the Medical Examiner Armed Forces Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Waste Water should be filed with and Mental Hygien is marked other th Chemical Engineer Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ other traumatic Cyrus William Rice Esther Knipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Patricia Lansdale/Wife 1708 Hickory Knoll Rd., Sandy Spring, MD20860 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 permit. Page 1 Department of I Important: If it any injury or o ð cemetery, crematory or other place) 1 Burial 2 St Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/6/2012 Alexandria, Metropolitan Crem. 21. Signature of Funeral Service Aicensee 22. Name and Address of Facility Muriel H. Barber Funeral Home with P.O. Box 5038, Laytonsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia days disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death the Unknown P.O. ed by t been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Hospital or Attending Physician: The law requires Completed Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Interstitial Pulmonary Fibrosis autopsy performed? has page 2 certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: At oldered filled in by the fundamental filled in Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

6×

State

18109 Prince

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fields, M.D.

D 34740

philip Dr., #200, Olney, MD

April 5, 2012

10f. Zip Code

1 Yes 2XXNo Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKET

Annapolis

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21401

10d. Inside City Limits

10g. Citizen of What Country?

16b. Kind of Business/Industry

14. Race - American Indian, Black, White, etc.

Own Home

White

1 Yes 2 XXIIo

10c. City, Town or Location

Funeral Director 28a-f show with the Maryland Examiner must be notified 5 23a should be filed within 72 hours after death ö Baltimore, Maryland 21215-0036 "natural", h and Mental Hygiene.
7 is marked other than "r permit. Page 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked a any injury or other traumatic eve once.

For State Registrar

Maryland

11. Marital Status

1 Never Married 2 Married

3℃Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Anne Arundel

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 🔀 No If Yes, Give

College (1-4 or 5+)

Armed Force

Year or Dates

8305 River Crescent Drive

15. Decedent's Education

(Specify only highest grade completed)

APR 1 0 2012

31. Date filed (Month

Physician/

Medical

Director

Funeral

þ

Completed

9

Examiner

Physician/ Medical Examiner requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director. A completely filled in by the fi

0	Robert H. Cook		(First, Middle, Maiden Surname) t H. Cochran									
	19a. Informant's Name/Relationship (Type, James Beirnes/son	Print)	19	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 640 North Governors Avenue Dover, Delaware 19904								
	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	20b. Place cemet	of Disposition (f ery, crematory of MOTE Cr	emator	- !	Date /7/201	2 Ba		, Maryland		
Į,	21. Sig Truneral Service Licensee	Lill	2						lor Fune: Annapolis	cal Home s, MD 21401		
	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ause on each line.	ry Art	ery Dis		, such as can	rdiac or resp	iratory arrest,		Approximate Interval Between Onset and Death		
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C										
ysician/medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes XXNo 4 Pregnant at time of death 5 Other (specify) Month											
a by Fr	Part II. Other significant conditions contrib	outing to death but	not resulting	in the underlyin	ng cause give	en in Part I.	2		d tobacco use contribute to the cause of d ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣			
completed by	Pulmonary Hyperte Congestive Heart 25. Was case referred to medical		-		00.00		_	4a. Was an autopsy performed′ ☐ Yes 2 ₩	death?	utopsy findings available completion of cause of		
	examiner? 1 Yes XXNo	oital:	+ 2 □ EB/O	utpatient 3 🗆	Othor	ce of Death (0						
icare:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day,)	28b.	Time of injury M	28c. Injury a work?	at	28d. D	escribe how inj	6 Other (Specury occurred	orty)		
ll certi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural F									ıral Route Number,		
Medic	29a. Certifier (Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the basis of example of example of the basis of the basis of example of the basis of	mination and/	or investigation,	in my opinion	, death occur	rred at the tin	ne, date and pla	ce, and due to the	cause(s) and manner state		
	29b. Signature and fifte of certifier 1)	Sulp	1	2	9c. License r D2	4768			Date signed (Mont April 5,			
	30. Name and address of person who comp Dr. William Dabbs	oleted cause of dear 277 Peni	th (Item 23a) I nsula	(Type, Print) Farm Ro	oad A	rnold,	Mary.	land 2	1012			

State

Registrar

To the Hospital or Attending Physician:

park

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13047 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Catherine T. Rinaman 5:45 PM 2012 Medical April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 □**X**F Days Hours 1/26/1941 Months 179-32-2392 70 FLDirector Usual Residence of Decedent and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Ocean Pines 1 Yes 2 XNo MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 102 Martinique Circle 21811 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced white permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Time Share Mgmt. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Duke Truby Bobbie Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Blossom Arch, Chesapeake, Bobbie A. Yoakem /daughter VA 23320 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Anatomy crematory or other place)
Signature of the control 1 Burial 2 X Cremation 3 Removal from State 4/5/2012 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral ervice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Jula 23a. Part 1. Enter the classes, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an ach line. Approximate Interval Between Onsel and Death Immediate Cause (Final Physician/ Altered Mental Status disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Stage Renal Disease ea55 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Mellitus Diabetes ears Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical pertension ears P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Division of Vital Records, 1 Tes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No ☐ Yes 2 🗶 N 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier April 5, 2012 н 0070020 Usun are 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Healthway Dr, Berlin, Diane Ceruzzi, MD, 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

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C7 26/1941

Physician/

Medical

Examiner

29b. Signatu

raci 31. Date filed (Month, Day, Year) APR 2 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please	Type or Pri						_	ole.		
For State Registrar	State of IVI	aryland / Dep Ce	ertificate		and ivi	entai mygier _{Reg.}	20	12 1304		
1. Decedent's Name (First, Middle, Las	t)				3. Time of Death					
Woodard Alexand	der Rober	ts, Sr.				April 14,	Day 2012	12:45 P ^M		
4a. Facility Name (if not institution, give	street and number)			b. City, Town, or Location of Death 4c. County of Death						
Golden Living Cent	ter	#	Westr							
5. Social Security Number 5 6. Social Security Number 1 6. Social Security Number 1 1 6. S		e (In yrs. last birthday 94 vrs		Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, Yea	r)	Birthplace (State or Foreign Country)		
Usual Residence of Decedent		94 Yrs.				Oct. 11,	1917	MD		
10a. State 10b. County Carro.	Ll	10c. City, Town or l Westmin					10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
10e. Street and Number 2265 Tommy's Dr.			10f. Zip C 211			10g.	Citizen of Wh			
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 If Yes, Give Year or Dates.		If Yes, specify	t of Hispanic Or Cuban, Mexica XNo Specify	n, Puerto F	ify Yes or No- lican, etc.)		American Indian, White, etc. White		
15. Decedent's E (Specify only highest gra		I (Giv	edent's Usual (e kind of work o	done during mos	st of workin	g 16b	. Kind of Busi	iness/Industry		
Elementary/Secondary (0-12)	College (1-4 or 5	+)	taff Ma	nager				Insurance Co.		
17. Father's Name (First, Middle, Last) Woodard W. Robe	rts			I		(First, Middle, Maid - Grimes	en Surname)			
19a. Informant's Name/Relationship (T) Woodard A. Robert		Son 19b. Ma	iling Address (S 5 Tom n	itreet and Numb y's Dr.	er or Rural , Wes	Route Number, City tminster	or Town, Sta	te, Zip Code) L157		
20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		20b. Place of Discemetery, cr Evergre	ematory or other	er place)	_		. Location - C	City or Town, State		
21. Signature of Funeral Service License	see .		22. Name and A	Address of Facili	^{ity} Prit Rd	ts Funera Westmins	arl Hon	ne & Chapel, P. MD 21157		
23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		the death. Do not e			cardiac or		,	Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence of):		4 ge				20 4,05		
	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pre				23d. Date Mont	of delivery h Day Year		
Part II. Other significant conditions o	ontributing to death b	ut not resulting in the	e underlying cat	use given in Part	: I.	23e. Did tobacc	5.7	oute to the cause of death?		
						24a. Was an autopsy performed	pri de	ere autopsy findings available for to completion of cause of eath?		
25. Was case referred to medical				26. Place of Dea	ath (Chaok		No 1	Yes 2 No		
examiner?	Hospital:	ent 2 FR/Outpot	ient 3 🗆 DOA	Other:		ne 5 🗆 Residence	6 Other	(Specify)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of inju (Month, Day	ry 28b. Time	of 28c	Injury at work?	2	8d. Describe how in				
3 Suicide 6 Could not be 4 Homicide determined	0	ury - At home, farm, s c. (Specify)	street, factory, o	office	2	28f. Location (Street City or Town, St		or Rural Route Number,		
(Check 2 Medical Exam	sician: To the best of iner: On the basis of ease se Practitioner: To the	xamination and/or inv	estigation, in my	opinion, death o	occurred at	the time, date and pla	ace, and due t	o the cause(s) and manner state		

H0661204

29d. Date signed (Month, Day, Year)

POOLE Rd WESTMINSTER MD 2115

2012

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

certificate

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March 29,2012 Frank Hunter Strickler 9:15am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Jan 20, 1920 Days Hours Washington DC **Director** 578-09-8310 1 XM 2 □ F 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3207 Leland St. 20815 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? UNKNOWN 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working ige 1 and 2 should be filed within 72 nt of Health and Mental Hygiene.

E: If item 27 is marked other than 'or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles B. Strickler Minnie E. Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellis B. Strickler/Wife 3207 Leland St., Chevy Chase, MD 20815 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery: 4-4-2012 Suitland, MD Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signatur all de 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Immediate Cause (Final Onset and Death tenosc leache .Placsician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (of as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury I and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to

10

State

Registrar

29b. Signature and title of certifier

11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ye gerry Gru Cite Lung Ly

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 13050 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert T. Smith 2:42p04 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick <u>Frederick Memorial Hospital</u> Frederick, MDAge (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 215-34-2923 1 **X** M 2 □ F Director 78 July 6, 1933 Maryland Usual Residence of Dece 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits must be notified Washington Maryland Hagerstown 1 Yes 2 No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a USA 13509 Spriggs Road 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 0 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" white 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) federal government 12 meat inspector Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o မ Mary Edna Taylor Richard Louis Smith Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy C. Smith - wife item 27 13509 Spriggs Rd., Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ō 1 🛮 Burial 2 🗆 Cremation 3 🗔 Removal from State Department of Important: If any injury or once, Cedar Lawn Mem. Park 4/14/12 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of ach line Interval Between Immediate Cause (Final Onset and Death Physician/ In Eumonia disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes ∠ ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Yo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Mann of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending М 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completely filled in by the Accident Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 06-2011

Registrar

only one) 29b. Signature

and title of certifier

Shah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

D60417

4-10-2012

Frederick MB 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 19:30 PM Patricia Apri 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, **Funeral** Months 212-52-4027 9/15/1948 MD 63 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State must be notified at 1 Yes XXNo Directo Millersville Anne Arundel 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö Pages 1 and 2 should be filed within 72 hours after death with 21108 USA 396 Aurora Dr Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ★ No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or Yes, Give 1 ☐ Yes 🛣 🔀 No Specify þ White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Geneologist Ancestry Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leila Clow ည James C. Phillippe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fitem 27 Is n other traum 396 Aurora Dr. Millersville, MD 21108 Husband of Health Glen Craig Surles 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o MXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/10/2012 Annapolis, MD Hillcrest Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. alg Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician days remocinação disease or condition resulting in death) /Medical Due to (or as a o sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 T Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 🕅 Natural 2 🗌 Accident 5 Pending investigation Injury 1 Tes 2 🗌 No eral Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier (check only 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, 24 hours within 2 To the I

State Registrar

lowen Laurer 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

an

MD strar's Signature 32. Rea

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

April 5, 2012

APR 1 0 2012

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Year William Gene Studebaker 0850 AM APRIL 701 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GLEN BURNIE WASHINGTON MEDICAL CENTER Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 90 534-12-2327 1**XX**M 2 □ F Director WA 10/4/1921 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Odenton 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n ō Funeral 21113 USA 2499 Amber Orchard Ct. Unit 302 12 Was Decedent Ever in LLS vvas Decedent Eve Armed Forces? 1 XXYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: WWII Specify. XX Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Gov't U.S. should be filed with and Mental Hygien is marked other th Civil Servant permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Minnie Culp Harold Studebaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Ropley Ave. Balwyn, Victoria Australia William J. Studebaker Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 4/7/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NASS Examine Due to (or as a consequence of): Due to (or as a consequence of): nding physician ause as the burial Physician/Medical The law requires that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ρ Month Day Pregnant at time of death
Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed Yes 2 No 2 🗌 No 1 Yes or Attending Physician: To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 4 hours after death.

uneral Director: After this
ely filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) D71488 4/3/12 M Jameru

Registrar
DHMH 17 Rev 06-2011

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301 Hospital Dr. Glen Burnie, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Patrick Nganga
31. Date filed (Month Day, Year)

APR 10 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ¿ Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 9. Birthplace (State or Foreign Hours 171-26-5399 **Director** 84 Dec 10 1927 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 3420 Newport Ave 21403 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Medical Examiner Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates W. W. 1 ☐ Yes 2X No Specify "natural", 3 Widowed 4 Divorced Specify: White Completed II 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me College (1-4 or 5+) 1 y r Elementary/Secondary (0-12) 12th Public Relations State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Surrick Sr. Florence Derbyshire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Surrick III(Son) 399 Forelands Rd. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 4-10-12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. M. Marne Rages Cof Sullit Sons Mortuary, P.A. . Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ HRONIC OBSTRUCTIVE PULMONARY nset and Death DISEASE Medical resulting in death) Examiner CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) EMENTIA Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav signed by the at be detached for Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 hknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate t completely filled in by the funeral director, pag 2 🗌 No Yes 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: 욘 MANDRI 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) t 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13054 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ ^{Day} 2012 9:45 A M D Starr 4 Mary Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Anne Arundel 2449 Kemper Road Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Min /15/1910 New York Director 062-01-9613 101 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director 1 Yes 2X No Anne Arundel Crofton Maryland 10e. Street and Number 10f Zip Code o 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 2449 Kemper Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ the Town Clerk Bergen <u>County Gov't</u> Ith and Mental Hygier 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Durack Robert Davre Page 1 and 2 should iment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Nancy B. Noren/ Daughter 2449 Kemper Road, Crofton, Marvland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 4/19/12 Venice Memorial Gardens Venice, Florida 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ THEGUT CA disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ate has been signed by the page 2 should be detached 1 ☐ res ∠ y 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) completed filled in by the funeral director, 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No 24 hours after death Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month

April 4, 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MITH 04 in ECEL(A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 021-28-9825 1 🗆 M 2 🕱 F 76 January 31,1936 Massachusetts Usual Residence of Deceden er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Anne Arundel 1 Yes 2 X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 Hearne Road #915 21401 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 XWidowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than
er traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Bartender Restaurant Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ unk. unk. of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Smith/Daughter-in-law 3688 8th Avenue, Department of Health Important; If item 2 any injury or other to once. Edgewater, Maryland 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Kalas Crematory 4 Donation 5 Other (Specify) 4-8-2012 Edgewater, Maryland Miller art 1 =-22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ IRA NEUMONIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? 1 Yes 2 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural work? 1 Yes 2 No 5 Pending ours after death.

leral Director: Ai 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the bes f my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of dertifier

Registrar

State

Name and address of person who complete

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31. Date filed (Mo.

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Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
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Physicia Medic	cal		LEX GREGO	RY	STEWA	ART			Month April	9	2012	3:09 A ^M
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Funeral Director		5. Social Security Number 577-80-7191 Usual Residence of Decedent	Sex 7. Age (I ■ X M 2 □ F	n yrs. last 53	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Dec. 24	, Year) 4, 1958	_ Cot	hplace (State or Foreign Intry) 1isiana
laryland 3a-f show iffied at	Director	10a. State 10b. County	George's		own or Loc Wie	eation						10d. Inside City Limits 1 🗶 Yes 2 □ No
with the N 23a or 26 ust be not	Funeral Dir	10e. Street and Number 3645 Elder 0a	ks Blvd #	7302		10f. Zip Code 20716				10g. Citizen of	What Co	untry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland brootstrent of Health and Mental Hygiene. Inportant: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	er in U.S.		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🗓 No	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. Ra Bla		
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Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	plications that collised the cause on each line. a. Due to (or as a collise) Due to (or as a collise) Due to (or as a collise)	e death. Death on sequence on sequence	ce of):	r the mode of dying crafor He h Lecka	Lear Lear	pardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of a line in the second of the second	Tetal de	eath 3 🗌	Ectopic pregnanc Other (specify)	у				ate of deli	very Day Year
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or Attenc after death Director:	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined	De Diago of Injuny	- At home Specify)	, farm, stre		Yes 2 🗌		28f. Location (S City or Town		er or Run	al Route Number,
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To the within To the Complete	_ r	29b. Signature and title of conflict	epleterse	of C	b	29c. License		,	2	29d. Date signe	d (Month)	
011		30. Name and address of person who		h (Item 23	a) (Type, Pr	int) A	ame	- 6	2001	noeu	cal	They
Stat	e	Judy Joseph-H 31. Date filed (Month, Day, Year)	erbert, MD 32 Registrar's	Signature					Annapo	our, no		21401
Registra	ar	ADD 1 2 201	2	1	hours	del						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death ne of Death Physician/ Enrique Sam Lio Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 578-58-2494 **Director** 1 🛛 M 2 🗆 F 81 June 25, 1930 Enping, China Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Prince George's Maryland 1 Yes 2 X No Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a c Funeral 6904 Saint Anne's Avenue 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, lan "natural", or itel Medical Examiner Armed Forces Black, White, etc. þ 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Asian Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry er than Restaurant Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the I Food Service Restaurant Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Enrique Chui Sam Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Enrique A. Sam / Son 6904 Saint Anne's Avenue, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Fort Lincoln Cemetery 4/15/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 on 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-transii Due to (o resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year signed by the at be detached for Pregnant at time of death 2 No g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 □ Yes 2 □ No 3 □ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hours after death.

Ineral Director: After this certificate has 1 Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one)

29b. Signature and title of certifier

person who completed cause of death (Item 23a) (Type, Print) ewa habe mi) = 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

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3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Good Lack Rd.

29d. Date signed (Month. Dav. Year)

MD. 20706

(anham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 9. 2012 Louise Virginia Singer 2:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Denton Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min **Director** 212-16-1526 95 1 □ M 2 🗓 F April 22, 1916 Maryland Usual Residence of Decedent 28a-f show 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Ty Yes 2 No <u> Maryland | Caroline</u> Denton ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral USA 401 North Sixth Street 21629 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 ₩ Widowed 4 □ Divorced Completed Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 H.S. Grad. Storekeeper Convenience Store and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Albert Gradles Dukes Mary Catherine Stafford permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Singer/son 309 South 2nd Street Denton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place Denton Cemetery 4/14/2012 Denton, Maryland 4 Donation 5 Other (Specify) Moore Funeral Home, P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 12 South 2nd Street Denton, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause _____ch line. Approximate Approximate nterval Between 3 set and D at Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) r as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? ģ Pregnant at time of death be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ပု 1 Yes Other: 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 2 No filled in by the Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of p

Day, Year,

31. Date filed (Month)

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mpleted cause of death (Item 23a) (Type,

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 8. Year Maria Julia Perez Tapias ŽÖ12 1:00pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5480 Wisconsin Ave #802 Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb 11, 1957 Days Hours Director 212-77-1240 1 □ M 2 🛭 F 55 Spain Usual Residence of Decedent 28a-f shov 10a. State 10c, City, Town or Location notified at by Funeral Director 10d. Inside City Limits MD Montgomery Chevy Chase 1 X Yes 2 No 5 Street and Number 10f. Zip Code 20815 10g. Citizen of What Country? must be 5480 Wisconsin Ave #802 23a United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White ö 1 Never Married 2 Married Yes 2 \(\text{No Specify:} \) Spanish White "natural", Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Tapias should be file and Mental F is marked o Aurelio Perez ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Cardenal Ilundain 11 3 7a 41013, Seville, Spain Alejandro Alvarez/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 4 Donation 4-11-2012 Falls Church, VA National Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons, INC ark & 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardiomyopathy Medical resulting in death) Examiner Sudden Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury Arrhythmia that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo Month Dav 1 Yes 2 L the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24a. Was an 24b. Were autopsy findings available has page 2 autopsy performed? prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificing populately filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Thomas S. Goldbaum MD 5530 Wisconsin Ave. Suite 515 Chevy Chase, MD 20815

of death (Item 23a) (Type, Print

29c. License number

D30885

29d, Date signed (Month, Day, Year)

April 10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O. 1. 0

			1 - For State Registrar	State Of Ivial		ertificate of L		тиентан гту	Reg. No.	012	13060
н	Physicia	n/	1. Decedent's Name (First, Middle, La	*				2. Date of De	ath	Vaar	3. Time of Death
	Medic		PHYLLIS LEE TR					APRIL	Bay	2012	21:50 M
	Examin	er	4a. Facility Name (if not institution, giv				r Location of Deat	h	4c. County of Death		
- F	Francis		CORSICA HILLS NU 5. Social Security Number 6.3		n yrs. last birthday,		CENTREVILLE nder 1 Year If Under 24 Hrs. 8. Date of			N ANNI	
	Funeral Director			9 (6	Months Days	Hours Min.	(Month, Da	y, Year)	9. Birting Coun	place (State or Foreign try)
			Usual Residence of Decedent		Yrs.			01/22/	1926	MAR	ZLAND
	/land f sho	tor	10a. State 10b. County	1	0c. City, Town or L	ocation				1	0d. Inside City Limits
	Man 28a- otifie	Director	MD QUEEN A	NNE'S	CHESTER						1 ☐ Yes 2 X No
	th the		10e. Street and Number			10f. Zip Code			10g. Citizen o		•
	th wit	Funeral	2641 CECIL DRIVE		21619				UNITE) STAT	ES
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Maryland 21215-0036	hour hatu dical	Specify: Spe							Business/Ind	dustry	
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٦	ould by Me Me mark		19a. Informant's Name/Relationship (Time Print	1,0,11			BECHINHI			
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ē,	1 and if Hea item othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location	n - City or To	wn, State
E	Page nent o int: If		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	CHESAPEAN	ČÉ ^{to} CŘÉMAŤ TER	ON 04/1	0/2012	STEVEN	SVILLE	E. MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	see //							
1106 SHAMROCK ROAD, CHESTER, MD 21619									ione, r.a.		
	and the second		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that a sed the one cause of the chine.	. //			or respiratory an	rest,		Approximate Interval Between
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687	rtifica ing p e as t	/Me	IF FEMALE:						77. 157.1		
×	eath certific attending d for use as	ian	23b. Was decedent pregnant in the past 12 months?		Fetal death 3	Ectopic pregnanc	y			Date of delive Month	ery Dav Year
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	1 Yes 2 No	4 ☐ Pregnant at tir 9 ☐ Unknown	me or death 5	Other (specify)				TOTAL	Day Icai
O.	requires that the des been signed by the s should be detached	by Pr	Part II. Other significant conditions				en in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of death?
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₹	nis ce I direc	70 E	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Othe	er: 4 Nursing H	lome 5 🗆 Resid	lence 6 🗌 Ot	her (Specify)	
o	ng Pl		27. Manner of Death → Natural 5 □ Pending	28a. Date of injury (Month, Day, Y	28b. Time of injury	of 28c. Injury work	at at	28d. Describe h			
Ö	tendi death. tor: A the fu	ific	2 Accident Investigation 3 Suicide 6 Could not	ne l		M 1 🗆	Yes 2 No				
Division of Vital Records,	or Atlanta	Certificate:	4 Homicide determined			reet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phy	rsician: To the best of my	knowledge, death	occurred at the time	, date and place,	and due to the ca	use(s) and mar	nner as state	ed.
	the Ho lin 24 the Fu	Med		niner: On the basis of examuse Practitioner: To the be							
	Vith Com		29b. Signature and title of certifier	MALLE	1	29c. License	number		29d. Date sign	ed (Month, E	Day, Year)
	17.05		7 //	11/ 11/		1/2	17935		7.7.	16	
	L. W		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)	Eso	ton, M	x 216	וח	
	Stat	e	31. Date filed (Month, Da) Feb.	201232. Registration	Signature A	Some de	, cary	001) 100	D	<u>~/</u>	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day April 7 2012 6:00 pm Courtland K. Townsend, Jr. Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1/3/1940 1 XM 2 □ Months Hours Min. Director 213-38-3271 72 <u>Washington DC</u> Usual Residence of Decedent 3a or 28a-f show be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? Funeral with "natural", or items 23a the Medical Examiner must 612 N. Pacific Ave. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3 - Widowed 4 - Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Lawyer Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Courtland K. Townsend, Sr Laura Hunt Townsend, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim D. Townsend / Wife Ν. Pacific Ave., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) State Crem. 4/9/2012 Millsboro, DE 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the sease, or complications that shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death Physici an disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate Yes 2 No 1 Yes 2 No ours after death.

Jeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Get trying Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Secretifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only ope 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 135131

Registrar DHMH 17 Rev 7/2009

Courtland

9715 Healthway Dr, Berlin, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

Pennie Savage,

31. Date filed (Month, Day, Year)

April 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13062 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day РМ Thomas 2012 Medical Winfield Tucker Apri1 7:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year Months Days **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 213-38-0045 1 🕅 M 2 🗆 F 87 09-07-1924 Maryland Usual Residence of Decede , or items 23a or 28a-f show miner must be notified at 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No Upper Marlboro MD Prince George's 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14300 Marlborough Lane 20772 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner Armed Forces?
1 X Yes 2 □ No If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. P.G. County Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the and Mental Hygien is marked other t Supply Manager Board of Education Be permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or any 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Tucker Eva Thomas Priscilla Armiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Hall, Niece 5749 Swamp Circle Road, Deale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Harmony Cemetery 04-10-2012 Owings, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. MK M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician. Pheumonia Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause (Disease or injury Date to for sels managements on To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year 2 🗆 No signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🏲 No Other: 1 Npatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: After 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46052 04/05/12 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) with 2001 Widhical Vonling in

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month,

Day, Year)

2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Geraldine Joy Walsh 2012 April 11:06 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care - Wheaton Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 577-42-1803 Director 80 2, 1932 Usual Residence of Decede January PA or than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10a State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11621 New Hampshire Avenue, Room 122 20904 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black. White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 e filed within 72 hours after Ital Hygiene. ed other than "natural", o 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bookkeeper Retail Food Be 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Henry Reeder Maria Reish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Newton / Daughter 28329 Fisherman Drive, Milton, Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprile 10. ò 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Dother (Specify) Metropolitan Crematory 2012 Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home, Inc. 500 University Blvd W. Silver Spring, MD 20901 23a. Part 1. Outer the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) 10 <u>vrs</u> Medical Due to (or as a consequence of): [/]Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Secondary Polycythemia Records, txx Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🖾 N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ♣ No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Ccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

Meera

Deena L. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signa

Shapiro 10810 Connecticut Avenue Kensington, MD 20895

D35336

April 10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13064 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4/8/2012 Physician/ 6:05 P M ZOFIA WALENTOWICZ . Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death ELLICOTT CITY HOWARD LIGHT HOUSE SENIOR LIVING CENTER . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 135-28-4421 1 □ M 2 🗓 F 7/11/1927 POLAND 84 Usual Residence of Dec show 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director or 28a-f sl 1 Yes 2 X No ELLICOTT CITY MARYLAND HOWARD 10e. Street and Number ō 10f. Zip Code s 23a o 10g, Citizen of What Country? Funeral within 72 hours after death with 21043 3100_NORTH_RIDGE_ROAD UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iter I Examiner I 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 SEAMSTRESS SEWING Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) မှ ANTONIA OLECHNOWICZ MICHAEL STEFANOWICZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i RICHARD WALENTOWICZ/SON ST. ANDREWS ROAD SEVERNA PARK, MD 21146 item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place) SAPEAK CREMATION ŏ 1 Burial 2 XCremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 4 22. Name and Address of Facilit LASTING TRIBUTES . Signature of Funeral Servi FUNERAL CARE 21401 HELFENBEIN & 814 BESTGATE NEWNAM CREMATION & ROAD ANNAPOLIS, MD 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) LYMPHOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director Affords: trar that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence eral Director; After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniurv work? 1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the less of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2Ad. Date signed (Month. Day, Year) 2017

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person,

31. Date filed (Month, Day Year) APR 1 0 2012

ANDREW LAZRIS

who com

hed cause of death (Item 23a) (Type, Print)

gistrar's Signatur

6334 CEDAR LANE #103 COLUMBIA, MD 21044

	For	State of M		epartment of He				2 3065
	State Registrar 1. Decedent's Name (First, Middle)	Last	(Certificate of De	eath	2. Date of Dea	Reg. No 20	
Physician/ Medical	Lelia Kather	ine Williams				Month April	Day `	Year 012 10:45 A ^M
Examiner	4a. Facility Name (if not institution 513 Coover Roa	, give street and number) ad		4b. City, Town, or L	ocation of Death		4c. County of Anne	f Death e Arundel
Funeral Director	5. Social Security Number 216-20-8879 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last birtho 86 yr	Months Days	Hours Min.	8. Date of Birtl (Month, Day August		9. Birthplace (State or Foreign Country) Maryland
laryland 3a-f shov ified at ector	10a. State 10b. County Maryland Anne	e Arundel	10c. City, Town o		napolis			10d. Inside City Limits 1 ☐ Yes 2 ★No
leath with the Maryland Items 23a or 28a-f sho ler must be notified at Funeral Director	10e. Street and Number 513 Coover Roa	ad		10f. Zip Code	21401		10g. Citizen of Wh	nat Country?
or amin	11. Marital Status 1 Never Married 2 Mar 3 XWidowed 4 Divorced	If Voc Givo	_	13. Was Decedent of His If Yes, specify Cuban, 1 Yes 2XXNo	, Mexican, Puerto I	cify Yes or No- Rican, etc.)		- American Indian, , White, etc. White
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rked othe rked othe ric event,	17. Father's Name (First, Middle, I Robert Brodie		<u>'</u>		18. Mother's Name Ann a	Maiden Sumame) mtman		
d 2 should alth and M 27 is mair r traumal	19a. Informant's Name/Relations Pamela Ayres/o	hip (Type, Print) daughter		Mailing Address (Street and 18 Wilton Av				ate, Zip Code) ryland 20910
age 1 and ent of Hee nt: If item y or othe	20a. Method of Disposition 1 Burial 2 XX remation 4 Donation 5 Other (8		cemetery,	Disposition (Name of crematory or other place))) 2012		City or Town, State
permit. P Departm Importal any injur	21. Signature of Funeral Service I			22. Name and Address	of Facility Jol	hn M. Ta	aylor Fu	neral Home lis, MD 21401
Physician/ Medical	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each line.	d the death. Do no					Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (drass	a consequence of)	sion	l			30 yrs
be es sicial buria	resulting in death) Last	d	a consequence or					
the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and repletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date Mont	of delivery th Day Year
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The law require: cate has been signified and any page 2 should I	atrial	fibrilla	tion				pr rmed? pr	ere autopsy findings available ior to completion of cause of eath? Yes 2 No
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th.: After this e funeral cate: T	27. Manner of Death 1 Natural 5 Pending Accident Investi	28a. Date of inju	ıry 28b. Tir	ne of 28c. Injury work?	at :		ow injury occurred	
al or Attending Physician: The law s after death. I Director: After this certificate has din by the funeral director, page 2 Certificate: To Be Comp	3 Suicide 6 Could 4 Homicide detern	not be		n, street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
the Hospital or Attending Ph in 24 hours after death. The Funeral Director: After thin apletely filled in by the funeral Medical Certificate: T	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e g Nurse Practitioner: To the	examination and/or	investigation, in my opinion	n, death occurred at	t the time, date a	nd place, and due t	to the cause(s) and manner state

V With

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Frederick Karkowski

139 Old Solomons Island Road

00054903

Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		101	rtificate of Death Reg. No. 20	2 3066								
Physic	cian	1. Decedent's Name (First, Middle, Last) Marie T. Williams	2. Date of Death Month 4/7/2012 Year	3. Time of Death								
	dica	marie 1. Williams	4///2012 4b. City, Town, or Location of Death 4c. County of De.	745 M								
) Laun		Genesis Spa Creek	Annapolis Anne An									
Funera Directo	_	5. Social Security Number 219-18-5361 6. Sex 1 M 2XXF 7. Age (In yrs. last birthday) 86 Yrs.		irthplace (State or Foreign country) MD								
DEJITIMOTE, IMARYIGH G Z L Z 13-UUJO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	- Concerning	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or U MD Anne Arundel Arundel Arundel 1626 Cananaro Dr. 11. Marital Status 12. Was Decedent Ever in U.S. 13	10f. Zip Code 10g. Citizen of What C	JSA								
Z I 3-UU30 in 72 hours after de: e. nan "natural", or ite Medical Examine	Ì	1 Never Married 2 Married 1 Yes XX No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Wh I □ Yes 2 □ No Specify: Specify:									
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yiand lid be filed Mental Hy narked oth	F		18. Mother's Name (First, Middle, Maiden Surname) Marie Schmich									
re, Mary and 2 should Health and N tem 27 is ma	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Edward Williams Son 1626 Cananaro Dr. Annapolis, Md 21409											
More, Page 1 and nent of Heal int: If item?		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, or	sition (Name of Date 20c. Location - City of natory or other place)									
parmit. Page 1 Department of Important: If i any injury or or	4 Donation 5 Other (Specify) Glen Haven Cemetery : 4/11/2012 Glen Burnie, Mi 21. Signature of Funeral Service Teensee 12. Name and Address of Facility Hardesty Funeral Home, P. A 12. Ridgely Ave. Annapolis, MD 21401											
h siciar Medic: Examine	al er Jauimak	Sequentially list conditions, if any, leading to immediate cause. Final Industrying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	dos resultations as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Madical	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Other (specify) Month	Day Year								
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DIVISION pital or Attendir ours after death. eral Director: Af			eet, factory, office 28f. Location (Street and Number or R City or Town, State) accurred at the time, date and place, and due to the cause(s) and manner as s									
To the Hos within 24 h To the Fun	Madical	(Check 2 Medical Examiner: On the best of my knowledge, dead only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and other of patings.	death occurred at the time, date and place, and due to the cause(s) and manner as the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the cause(s) and manner a 29c. License number 29d. Date signed (Mon	e cause(s) and manner stated. as stated.								
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Si Regis	tate strar	31. Date filed (Month, Day, Year) APR 1 0 2012 32. Registrar's Signature	back									

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Physician/ Medical	ı.		Sand	ra	L /	4nce		Month 04	2 2	3 2010	
Examiner	ľ	4a. Facility Name <i>(if not institution, g</i> 1050 Marton Str				. City, Town, or I Laure 1	Location of Dea	th		County of Death	
Funeral	- 1	5. Social Security Number 6		(In yrs. last	birthday) If	Under 1 Year nths Days	If Under 24 Hr Hours Mir	8. Date of Bir (Month, Da	ti Feb	12, 1949 Birt	hplace (State or Foreig intry) y land
Director	-	215-56-3184 Usual Residence of Decedent		63				Vec. 1 <u>€</u>	13	ys I Mar	
or 28a-f sho	5	10a. State 10b. County	Coongols		own or Locatio	n					10d. Inside City Limits
perillinore, Maryland ZIZIO-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Funeral Director		Maryland Prince 10e. Street and Number	deorge s	Laure		Of. Zip Code			10g. Citi	izen of What Co	untry?
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fter dea		11. Marital Status 1 ☐ Never Married 2 💢 Marrie			If Yes	specify Cuban	ı, Mexican, Puei	to Rican, etc.)		14. Race - Amer Black, White	, etc.
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and 2 Health Item 27	2	James David Anc		20b. Plac	e of Disposition	(Name of		aurel, M		cation - City or	Town, State
Page 1 nent of ant: If i	1	1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			etery, cremator t Crema	tory	4/2	5/2012		dorf, M	D
permit. Departr Import any inji		21. Signature of Funeral Service Lice	orisee		22. Na	ne and Address		leck Fun ing Road			20707
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Be Completed by Physician/Medical	January III	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Petal de	eath 3 🗌 Ect	opic pregnancy er (specify)	,			23d. Date of deli Month	ivery Day Year
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in 24 hours in 24 hours he Funeral pleted filled		(Check 2 Medical Exa	hysician: To the best of raminer: On the basis of ex urse Practioner: To the b	amination ar	nd/or investigation	on, in my opinion	, death occurred	at the time, date a	and place,	and due to the o	ause(s) and manner sta
withir comp		29b. Signature and title of certifier	Park a	sry)	29c. License				e signed (Month	
		30. Name and address of person wh	rk, 105	Digit	tal Di	#4	, Lin	thicus	n	MD	21090
State Registrar	3	11. Date filed (Month, Day, Year)	2012 32. Poistrar	s signature	has	2)					
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 910 M 0× 3018 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Silve 12409 02-61 OY 8. Date of Birth (Month, Day, Year) March 12, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2XXF Canada 1916 3 -40-Z3 Director 96 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County at the Maryland Director notified a 1 Tes 2XXNo Silver Spring Maryland Montgomery 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or by Funeral with 1 U.S.A. 20904 12809 Kilgore Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes Yes, Give 1 ☐ Yes 2 🔀 No Specify: White 3XXWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Grade 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mabel Anderson Alan Busby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1702 Sassafras Drive Wesley Chapel, Florida 33543 daughter Marion Patton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Durial 2 A Cremation 3 Removal from State Arundel Crematory 4/26/2012 Odenton, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. Laurel, 20707 CR Maryland 313 Talbott Avenue M00770 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List o nly one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Cause (Disease or iinjury Examiner Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: Yes 2 2. No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes npleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 I 5. Residence 6 Other (Specify) Certificate: To Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work' 1. Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) innature and title of confie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State 6

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death . Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last Physician/ ARNES Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Kandallstown Hospie Seasons 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Country 70 7132 Director 1 🗆 M 2 🗶 F MD idence of Decedent or items 23a or 28a-f show miner must be notifled at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No NA timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 2122 3 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U.S "natural", or item edical Examiner n 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 9 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ta 101 Barnes 19a. Informant's Name/Relationship (Type, Print) Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barnes Ann MU Edmondso 10 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Lansdowne ZION Cemetery 22. Name and Address of 165 eph L . Signature of Funeral Service Ligensee Batto. AID 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month ģ Pregnant at time of death , the £ 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ whknown Division of Vital Records, Completed 24a, Was an 24b. Were autopsy findings available cate has l performed certificate 25. Was case referred to medical nalieu 26. Place of Death (Check only one) Be examiner' 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ျှ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of the funer of the function of the funer of the funer of the funer of the funer of the function of the funer of the function of the function of the funer of the function of the funct 5 Pending injury Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifier 128593

304

DHMH 17 Rev 06-2011

State Registrar ASNEEM

31. Date filed (Month, Day, Year)

WINGS

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Day 2012 Year 11:15 am Robert Bogusky, Sr. 24 Stephen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13609 Devonbrook Road Baltimore Baldwin Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Yea Months Hours 098-32-5933 1 🛚 M 2 🗆 F New York **Director** 71 Aug 13, 1940 Usual Residence of Decedent 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director ms 23a or 28a-f sl must be notified Baldwin Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21013 U.S.A. 13609 Devonbrook Road "natural", or items edical Examiner mu 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. rear or Dates. 61-65 Specify 3 Widowed 4 Divorced White other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Metallurgical Engineer Steel other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o ပ Puhalla Bogusky Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : 715 Milldam Road, Towson, MD 21286 Stephen R. Bogusky, Jr.-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot Date Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/27/12 Hydes, MD 4 ☐ Donation 5 ☐ Other (Specify) St. John Cemetery 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death IN PARCET Physician/ MOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as. IF FEMALE ase a yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen CEREBRO VASULAR 24b. Were autopsy findings available prior to completion of cause of death? teciden 24a. Was an After this certificate has performed? 1 Yes 2 No Hospital or Attending Physician; 24 hours after death. Funeral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🗷 Residence 6 🗌 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending Accider
Suicide Accident 2 \ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4/24/2012

Robert Bogusky, Sr

Stephen

State Registrar

(Check only one) 29b. Signature an

Sea

2012

DHMH 17 Rev 06-2011

address of person who completed cause of death (Item 23a) (Type, Print)/

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ASR MILL RD

THOENIX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Mary	•			Mental Hy	giene Reg. No. 20	12	13071		
		Registrar 1. Decedent's Name (First, Middle, Last,)	Cei	tificate of E	<i>Death</i>	2. Date of De			3. Time of Death		
Physic Med		Evelyn Block			April 25, Da 2012					4:10 A M		
Exam		4a. Facility Name (if not institution, give s Gilchrist	treet and number)		4b. City, Town, or Towson		th	4c. County of Death Baltimore				
Funera		Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th		e (State or Foreign		
Directo	r	Usual Residence of Decedent] M 2 X] F	93 Yrs.	Worting Days	Tiodis Willi	11/19/		laryla			
land f show d at	į	10a. State 10b. County		c. City, Town or Lo					10d.	Inside City Limits		
e Man r 28a- notifie	Director	Maryland Baltimo	re	Cockeysv						1 ☐ Yes 2X☐ No		
with th 23a o rst be	erall	4 Twinleaf Ct.			10f. Zip Code 21030			10g. Citizen of Wh	at Country	?		
death items	Funeral		12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-	14. Race -	American			
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		l ☐ Yes 2 🔀 No		to riloan, oto.,		White, etc.			
5-00 2 hours natur	plete	15. Decedent's Edi (Specify only highest grad	ucation	16a. Deced	ient's Usual Occupa kind of work done o	ation	dina	16b. Kind of Busi	iness/Indus	try		
Maryland 21215-0036 2 should be filed within 72 hours after th and Merttal hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	o NOT use retired) maker	uring most or we	irkirig	Own Hom	ie			
filed wi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surname)				
Varyland 2 should be filed v h and Mental Hyg 7 is marked othe traumatic event,	P	John Huber				Ella I	Haney					
Mar 2 shou ith and 27 is no traum		19a. Informant's Name/Relationship (Type Alan Block / son	e, Print)		ng Address (Street a Starburs			r, City or Town, Stat ore, Mary				
1 and 2 s of Health item 27		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Date	20c. Location - C				
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other		1 🕅 Burial 2 □ Cremation 3 □ f 4 □ Donation 5 □ Other (Specify)	Removal from State	Druid Ri		4/2	7/2012	Baltimor				
Baltimol permit. Page 1 Department of Important: If i any injury or or		21. Signature of Equeral Service Anse	Jam.	u 22	. Name and Addres	s of FacilityRuo	ck Towson owson, Ma	n Funeral aryland 2	Home 1204	, Inc.		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximation of the mode of dying, such as cardiac or respiratory arrest, interval Bernard										
Physician Medica		Immediate Cause (Final disease or condition resulting in death)	Debilili						Or	nset and Death		
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p tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):								
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certificate be executed and ing physician and use as the burial-transit	dical		ıl									
6876 sertificat Iding ph	/Mec	IF FEMALE:	0 - 16									
Box 6 death ce he attend	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pour 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	,	y Year		
P.O. B that the de ned by the e detached	hysi	9 Unknowh	9 Unknown									
ords, P.O. Box 687 requires that the death certific. been signed by the attending is should be detached for use as		Part II. Other significant conditions cor Cultural Appl	itributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu		ause of death?		
ords requii	lete						24a. Was			findings available		
Aec	Completed by						autop perfo 1 🗌 Yes	osv prio	or to compleath?	etion of cause of		
ician; Terrifica	Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Che		22,110		,		
Of VI	e: 10	1 Yes 2 No	1 Inpatient 28a. Date of injury	2 ER/Outpatien 28b. Time of	t 3 DOA Othe	4 ☐ Nursing I	1	lence 6 C Other (Specify)	tospiee		
on C anding sath. or: Afte	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	ar) injury	work*		254. 5656/156/1	on injury occurred				
Division of Vital Records, tal or Attending Physician: The law requires staffer death. In Director, After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2 should be a signed and a staffer the funeral director.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (St	At home, farm, streecify)	eet, factory, office			tion (Street and Number or Rural Route Number, or Town, State)				
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and or investigation and other and							the cause(s	s) and manner stated.		
To th withir To th	2	OCh Cianatura and title of portion		100 11								
		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, P	rint) 4105	130000	use M	D 21206	<u>'</u> +	-		
	ate	31. Date filed (Month, Day, Year) 12	32. Registrar's S	nature face	1	·Cucar	muse)					
Regist	rar	Will So Fore	Volume 1									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State of Maryland		artment of Health a	nd Mental Hy	giene °				
_		_	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	1	Reg. No. 20	2, 13072			
П	Physicia		Alma Class			2. Date of De Month	eath Day Year	3. Time of Death			
may	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of		4c. County of De				
أمسوي			Anne Arundel Medical Center		Annapolis		Anne Aru				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last $148-24-0647$ 1 \square M 2 F 83		If Under 1 Year If Under 24 Months Days Hours		th 9. B	irthplace (State or Foreign ountry)			
	Director		Usual Residence of Decedent	Yrs.		July 6	,1928 New	York			
	land show	ţō	10a. State 10b. County 10c. City,	Town or Loc	cation	•		10d. Inside City Limits			
	Mary 28a-i otifie	Director		polis				1 ☐ Yes 2 🔀 No			
	ith the 3a or t be r		10e. Street and Number		10f. Zip Code		10g. Citizen of What C	Country?			
	ath w	Funeral	11 Southgate Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	13 \	21401 Vas Decedent of Hispanic Origin	n2 (Specify Vas or No-	USA	ada a fada a			
9	or ite		Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If	Yes, specify Cuban, Mexican, I	Puerto Rican, etc.)	14. Race - Am Black, Whi				
21215-0036	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2X No Specify:		Specify: Wh	ite			
15-	72 ho n "nat fedica	nple	15. Decedent's Education (Specify only highest grade completed)	(Give h	lent's Usual Occupation kind of work done during most o	of working	16b. Kind of Business	s/Industry			
212	vithin liene. rr thai		Elementary/Secondary (0-12) College (1-4 or 5+)		NOT use retired) Maker		Own Hom				
þ	filed within all Hygien dother the svent, the	o Be	17. Father's Name (First, Middle, Last)			's Name (First, Middle,					
Maryland		မ	John Max Weyer		Hilda	Bever					
Mar	and and is r	1	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number						
ď	permit. Page 1 and 2 s Department of Health i Important; If item 27 i any injury or other tra		Hilary Clap/daughter 20a. Method of Disposition		outhgate Avenue						
Baltimore,			1 Burial 2 V Cremation 3 Bemoval from State Cer	metery, crem	ematory, Inc. 04	Date // /25 /2012	20c. Location - City of Baltimore,				
altii	mit. Poartm portal portal / injur	- 5	21. Signature of Funeral Service LicenseeStephanie Cust	ter 22	Name and Address of Facility	Cremation	Society of	Maryland Inc			
ä	Del m any	1 ()	Deamin Clip	29	9 Frederick Ro	oad Baltimo	ore,Marylan	d 21228			
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					Approximate Interval Between			
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	uted Id ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
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Box	eath c atten d for u	Physician/Me	in the past 12 months? 1 Live Birth 2 Fetal of 4 Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of de Month	Day Year			
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Ä	n: The ficate or, pag	e Co	25. Was case referred to medical		00 81	1 Tes		es 2 12 No			
Vita	ysicia s certi direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 P	R/Outpatien	26. Place of Death Other:		dence 6 Other (Spe	-(6.)			
of	ng Ph ter thi ineral			8b. Time of injury	28c. Injury at work?		now injury occurred	Cny)			
ion	ttendir death. tor: Af the fu	ifica	2 Accident Investigation		M 1 Yes 2 N	0					
Division of Vital Records,	or At after c Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	28f. Location (S City or Tov	Street and Number or Ru vn, State)	ıral Route Number,			
Ω	spital sours reral /		29a. Certifier 1 Certifying Physician: To the best of my knowled	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director. After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for	Medical	(Check 2 Medical Examiner: On the basis of examination a only one) 3 Certifying Nurse Practitioner: To the best of my	and/or investi	gation, in my opinion, death occu	irred at the time, date a	and place, and due to the	cause(s) and manner stated.			
	Nith with		29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	th, Day, Year)			
			-/outs force 120		V 015529	2 M(D)	04-23	-2015			
_			30. Name and address of person who completed cause of death (Item 2	3a) (Type, Pr	rint)	IFA.	vanale	مرسون (زیار			
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	el	DO(5524	1 111	Kapoly,	VIV 2145			
	Registra	ır	APR 2 6 2012 Sunt A.	park							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Midgle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 Year 2 530 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Locat 4c. County of Death **Examiner** Case \S\ 90 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct 9, 1948 242-78-6958 63 North Carolina Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Harford Havre de Grace Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21078 833 Erie Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1968

1X Yes 2 No 1968

If Yes, Give 1971 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 1971 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Iron Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Claira Elliott Alfred Cranfill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1507 Woodbine Road Airville, PA 17302 Hannah Cranfill, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4/26/12 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Tuomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Right Parotid Carcinoma disease or condition resulting in death) 3 years Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or linjury Examine Supplied for the second continuous of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 1 L Yes 2 L 9 D Unknown the cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 140054439 24,2012

DHMH 17 Rev 7/2009

State Registrar VA Waryland Heath Care System.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

incent A. giminaro. Do

31. Date filed (Month, Day, Year)
APR 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day 2012 April 10, Physician/ 2:21 PM M Anastasia S. Cooper Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Talbot Easton 623 S. Washington Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav) **Funeral** Month: Davs Hours Min (Month, Day, Year) 216-14-9004 **Director** 1 □ M 2 🗓 F Yrs. Sept 5, 1920 91 Maryland Usual Residence of Decedent or 28a-f show e notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 X No MDTalbot Easton 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 21601 USA 623 S. Washington Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. "natural", or item ledical Examiner n Armed Forces? Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify: 3 X Widowed 4 □ Divorced white Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than '9 any injury or other traumatic event, the Me any injury or other traumatic event, the Me gince. Elementary/Secondary (0-12) College (1-4 or 5+) housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Kenly Startt Nora Genevieve Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy A. Cooper/daughter 8186 June Way #104 Easton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 22 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest repair heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYELOCYTIC LEUKEMIA 1 month disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? jo Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death?
1 Yes 2 No Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending s after death.

I Director: Aff
ed in by the fu Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signatur

\$221 TEAL DRIVE, EASTON, MARYLAND DR. DAVID H. SMITH, 31. Date filed (Month, Day, Year) APR 2 6 2012

and title of certific

dress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D39887

29d. Date signed (Month, Day, Year)

4-16-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month APRIL 8040 2012 W KICHARD CARR 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F 71 216-36-0112 Aug. 21,1940 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Dundalk Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 37 Waterview Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2K No Specify. Specify: White 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 8 Years Contractor Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth M. Rhodes Charles Carr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Waterview Road Dundalk, Maryland Beverly Carr (Daughter) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park Cem.4/26/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed uStin A. 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the shock, or heart failure List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest immediate Cause (Final

Physician /Medical **Examiner**

Department of Important: If it any Injury or conce.

Physician

/Medical

Examiner

Funeral

Director

or 28a-f sl

5 must be

23a

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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MD

with the Maryland

death v

burial-t þ certificate within 24 hours at er death.

To the Funeral Director. At completely filled in by the fi

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death)	Due to (or as a conseq	Hence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	ARCINOMA uenos of)			
d	,				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	al death 3 🗌 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed 1 Yes 2	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2	ER/Outpatient 3 1	OOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	t and Number or Rural Route Number, ate)
	sician: To the best of my kno ner: On the basis of examina and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	8-	2	9c. License number		Date signed (Month, Day, Year)

LES-000

APRIL 22, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

State

Registrar

back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meraf Wolle, M.D.

APR 2 6 2012

31. Date filed (Month, Day, Year)

			For	State of	f Marylan	•	artment of H		Mental Hy	giene	0 1 0	10076
			State Registrar	Look		Cer	tificate of D	Death	0 0-1(0-	Reg. No. 2	012	130/6
	Physicia		1. Decedent's Name (First, Middle Dena	R. Came	ron				2. Date of De Month	Day	Year 2012	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution				4b. City, Town, or	Location of Deat		4c. County		
more of			Somerford Assi					umbia			ard	
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. Ia 89		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ıy, Year)	9. Birthp Count	lace (State or Foreign ry)
			217-26-5219 Usual Residence of Decedent	I LIM ZXIF	09	Yrs.			October	22,1922	Ma	ryland
	land show dat	tor	10a. State 10b. County		10c. City	y, Town or Loc	cation				11	0d. Inside City Limits
	Mary 28a-	Director		ford		For	est Hill					1 Yes 2X No
	ith the	ral	10e. Street and Number	a. 1			10f. Zip Code	1050		10g. Citizen of		
	ems arm	Funeral	315 G Willrich		dent Ever in U.S	6. 13. V	Vas Decedent of Hi	1050 spanic Origin? (S	Specify Yes or No-		ed St	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ed by F	1 ☐ Never Married 2 ☐ Mar 3 🙀 Widowed 4 ☐ Divorced	If Yes Give	2 🗶 No	"	Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		ck, White, e	ite.
ည် က	'natu	olete		nt's Education est grade completed)		16a. Deced	lent's Usual Occupa	ation	nrkina	16b. Kind of B	usiness/Inc	lustry
2	hin 72 ne. than '	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)	life. D	O NOT use retired)		,,,,,,,,	05.	n Hom	
N .	Hygie Hygie other ant, th	Be C	8 17. Father's Name (First, Middle, I	ast)			Homemake	· · · · · · · · · · · · · · · · · · ·	ame (First, Middle,			
au	be filk ental 'ked c	인	Peter Rose						ne Karame		-/	
ary	and Mais mai		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Number or R	ural Route Numbe	er, City or Town,	State, Zip C	ode)
Ξ	ealth a 27 in 27 iner tra		Joseph Cameron	Jr./Son			dgehill :	Drive, E	Bel Air,			
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (\$		State 20b. P	emetery, cren West	sition (Name of natory or other plac Arundel ematory	Apr: 20	il 24, 012	20c. Location Odenton		
Balt	permit. Departr Imports any injs		21. Signature of Funeral Service	Licensee	M01386		Name and Address Naldson Il Annap	ss of Facility Funeral olis Roa	Home & G	Cremator ton, Mar	y. P. yland	A. 21113
T			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that ca	aused the deatl							Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition		phoma							Onset and Death
	Medical Examiner		resulting in death)	Due to (c	or as a consequ	uence of):						
	FA E	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequ	uence of):						
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury									
	executed an and irial-transi	EX	that initiated events resulting in death) Last	Due to (d	or as a consequ	uence of):						
2	te be hysicia the bu	dical		d								
289	certifica nding p use as t	/Me	IF FEMALE:	23c. If yes, outo	come of pregna	ncv				00.1.5	A SALE	
Rox.	death ne atte ed for	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live E	Birth 2 🗌 Feta nant at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	Ey			ate of delive	Day Year
л О	that the ned by e detail	by Pt	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to th	e cause of death?
ds,	quires en sig ould b	ted t							1 🗆	Yes 2 No	3 Prob	ably 4 Unknown
Division of Vital Records,	rsician: The law requires that the scrifficate has been signed by the director, page 2 should be detach	Completed							24a. Was auto perf 1 \(\sum \) Yes		Were autop prior to cor death? 1 \(\sum \) Yes	osy findings available impletion of cause of
<u> </u>	cian: ertifica ector,	Be (25. Was case referred to medical examiner?	Hospital:				ace of Death (Ch	eck only one)		Collad	1 \ - 2 5 - 1 1 -
<u> </u>	Physic this c	<u>1</u>	1 Yes 2 No	28a. Date o	Inpatient 2	ER/Outpatier						Living facility
0	ding I.h. After funer	cate	1 ☑ Natural 5 ☐ Pendi		h, Day, Year)	injury	28c. Injun work M 1 🗆	yat (? Yes 2 □ No	28d. Describe	how injury occur	rea	
IVISIO	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Place	of Injury - At ho ng, etc. (Specify		eet, factory, office			Street and Numb wn, State)	er or Rural	Route Number,
_	e Hospita 124 hours E Funeral	Medical	(Check 2 Medical I	g Physician: To the be Examiner: Dn the basi g Nurse Practitioner:	is of examination	n and/or invest	tigation, in my opinio	on, death occurred	d at the time, date	and place, and du	ie to the cau	use(s) and manner stated.
	To the vithir comp	2	29b. Signature and title of certifie				100 11					3 1/2 1
	10 pm		30. Name and address of person		e of death (Item	1 23a) (Type, F	Print)	05746	D 212	4/23	/12	
			NSRaj apaksemo		nsm/		3 Baldin	nore M	D 515	07		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 2	1 0	egistrar's Signa	ture						
_		-		I Mad III	47							

			FOR		artment of He		ental Hygie		0 10077
			State Registrar	Ce	rtificate of De	eath		, No. 201	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ronald E. Duncan				2. Date of Death	3 ^{Pay} 2012 ^{Year}	3. Time of Death 12:15 a.M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Dea	1
	Funeral		Gilchrist Hopsice 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		f Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
u	Director		216-58-3347 X□M2□F	60 Yrs.	Months Days I	Hours Min.	(Month, Day, Ye 12–12–195		ountry) MD
	and show	ان و	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits
	Maryl 28a-f notified	irec	MD n/a	Balt	imore				1 X Yes 2 □ No
	vith the 23a or st be r	Funeral Director	10e. Street and Number 608 Tunbridge Road		10f. Zip Code 21212	2	100	g. Citizen of What C USA	ountry?
	death vitems		11 Marital Status 12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spec Mexican, Puerto F	cify Yes or No-	14. Race - Am Black, Whi	
38	s after (al", or Examir	d by	1 Never Married 2 Married 1 Yes 2 X I If Yes, Give 3 Widowed 4 X Divorced Year or Dates.	No	1 ☐ Yes 2 【XNo				rican-American
2-0	2 hours "natur edical I	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation	on ing most of workin	16	6b. Kind of Business	3/Industry
7121	ithin 7 iene. r than the Me	Com	Elementary/Secondary (0-12) College (1-4 or 5-	+)	DO NOT use retired) Spector			ity of Balt	imore
nd .	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle, Last)				(First, Middle, Mai	den Surname)	
ızyla	ould be d Meni marke matic	2	Melvin Duncan 19a. Informant's Name/Relationship (Type, Print)	10h Mai	ling Address (Street and		ny Mae Cart		(in Code)
Baltimore, Maryland 21215-0036	1 and 2 shoot Health ar item 27 is other trau		Donald E. Duncan Sr.,/ Brother		Wilke Avenue,				,p 6500)
ore	permit. Page 1 and 2 should be for Department of Health and Menta Important; If item 27 is marked any injury or other traumatic enonce.		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State		ematory or other place)	į		c. Location - City o	
altin	nit. Pagartmer ortant injury		4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licensee	Oak Lawn (Lemetery 22. Name and Address	5-1-2	OIZ E	Baltimore, N Ome P.A. of	1D Baltimore Co.
ñ	Dep Imp		May Celey		9200 Liberty I	Road, Randa	allstown, M	D 21133	
	Medical Examiner	niner	Sequentially list conditions, Due to (or as a	consequence of):	Cance				Approximate Interval Between Onset and Death
98760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Medical Examiner	d	consequence of):					
). Box (requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ds, P.C	quires that en signed k	ò	Part II. Other significant conditions contributing to death be	ut not resulting in the	underlying cause giver	n in Part I.	23e. Did tobar		to the cause of death?
Division of Vital Records, P.O. Box 687	: The law re cate has be r, page 2 sh	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of es 2 No
/ita	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatia	ent 2 🗆 ER/Outpati	_ Other:	e of Death (Check		ce 6 Other (Spe	ecity) Hospice
of	frer this		27. Manner of Death 1 Natural 5 Pending 28a. Date of injure (Month, Day)	y 28b. Time	of 28c. Injury a work?	t 2	28d. Describe how		The state of the s
ivision	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certificate:	2 Accident Investigation	iry - At home, farm, s :. (Specify)		es 2 No	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	ne Hospita in 24 hours ne Funeral pletely filled	Medical	29a. Certifier 1 X Certifying Physician: To the best of (Che only one) 3 County of County Over 1 Co	kamination and/or inve	estigation, in my opinion,	death occurred at	the time, date and	place, and due to the	e cause(s) and manner stated.
•	To the voith com		29b. Signature and title of cartifier M.	\mathcal{D} .	29c. License n			d. Date signed (Mon	
	LOV .		30. Name and ad least of person who completed cause of de Philip Shaheen, 67 31. Date filed (Month, Day, Year) 32. Aedistra	eath (Item 23a) (Type, OI N. Ch	orles St	- *410	s, Bal	timen	5, MD21204
	Sta Registr		APR 2 6 2012	ar's Signature	arts				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Shaina Ellette 11:15 AM Degroat - Jones 0 SIOS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore University of Maryland Medical Center Baltimore 5. Social Security Number Sex If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 🗆 M 2 💢 F Months Days Hours Month Day, Year 2012 15 Mary land Director Apr infant Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 V No Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 140 Willowdale Drive #31 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene is marked other tha infant infant infant infant Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jeremy Jones Alyssa DeGroat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Medical Ctr 22 S. Green Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in stat cemetery, crematory or other place) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Reltimore. MD 21201 mald Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the control of the cause on each line. shock Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Sovere Premoty Medical Due to (or as a consequence of) Examiner Due to (or as a surrequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗹 No မြ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 To the I within 2

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

29c. License number

St. Bouto

29d. Date signed (Month, Day, Year)

12-03033 Elisesia Dabnev Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

esia Dabney		State of Maryland / Department of For State Certificate of Certificate	f Health and Mental Hygiene f Death Reg. No. 2012 1307									
Physiciar dical Examin	n/	2. Date of Death Month Day April 18, 2012 3. Time of Death 1340 hrs										
		15esia Uabney 4a. Facility Name (if not institution, give street and number) 5610 York Road Apt G3	4b. City, Town, or Location of Death Baltimore 4c. County of Death									
Funeral Director	í	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F The security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Min.									
ow any	ľ	Joual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local MD NA Battimore	10d. Inside City Limits 1 Yes 2 No									
death with the Maryland or items 23a or 28a-f show must be notified at once.	Ø	MD NIA Baltimore 10e. Street and Number 5610 YORK Rd. Act. G	10f. Zip Code 10g. Citizen of What Country? 21212 USA									
H 7 7 7	L	11. Marital Status 12. Was Decedent Ever in U.S. 13. W Armed Forces? 1 Yes 2 No	as Decedent of Hispanic Origin? (Specify Yes or No- res, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.									
IMORE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner or other events are not events and the events of the	leted by	Elementary/Secondary (0-12) College (1-4 or 5+)	Yes 2 No specify: Specify: Specify: Black at's Usual Occupation (Give kind of work done lost of working life, DO NOT use retired) 16b. Kind of Business/Industry									
21215-0()36 21215-0()36 build be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	Be Completed	12th Nursin 17. Father's Name (First, Middle, Last) Arthur Johnson	9 Aid HealthCare 18 Mother's Name (First, Middle, Majden Surname) Gevalding, Dabney									
MD 212 d 2 should be lth and Menta n 27 is marke numatic event] م	19a. Informant's Name/Relationship (Type, Print) Jacqueline Smith - Sister 316	g Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Calhoun St. Balto. mp alaa3									
Saltimore, ML bemit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum		1 Burial 2 Cremation 3 Removal from State crematory or o	natory 4-30-12 CatonsVille, mo									
	23a Fapt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Medical Examiner		23a Part / Entier the disease, or complications that caused the death. Do not enter the Inode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):										
	튑	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated										
and and	edical Exa	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED										
0 20	5 I	FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Female 1	tal death 3 Ectopic pregnancy Month Day Year ther (Specify)									
res that the d signed by the	y P	Part II. Other significant conditions contributing to death but not resulting in the Sickle Cell Disease; Obesity	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown									
In a strength of vices in the law requires the dear dear dear dear dear dear dear dea	Completed	Olekie Geli Bisease, Obesity	24a. Was an autopsy findings available prior to completion of cause of death?									
ysician: The his certificat director, pag	မှု မ	25. Was case referred to medical 26.Place of Death (Check only one)										
ing Physic After this c	욘	examiner? 1										
tal or Attend ars after death al Director: lled in by the	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street 4 Homicide (Specify)										
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	dical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, and due to the cause(s) and manner as stated. tion, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
H S H S	4	29b Signature and title of certifier Pollet is	29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2012									
			900 W. Baltimore Street, Baltimore, MD 21223									
Sta Registr		31. Date filed (Month, Day, Year) 2012 32 Registrar's Signature APR 2 6 2012	No.									

OCME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

a3mmAHOM 31. Date filed (Month, Day, Year)

DDUGNI

Registrar's Signatu

For State Registrar

1. Decedent's Name (First, Middle, Last)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burital-transit

Division of Vital Records, P.O. Box 68760,

E	12 Years	College (1-4or 5+)	Homemak	er		Own	n Home		
e C	17. Father's Name (First, Middle, La	ast)		18. Mother's Nar	ne (First, Middle, N	1aiden S	Surname)		
<u>ල</u>	John J. Blair	c			Frederic	ka I	Decker		
	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Stre						21161
	Thomas S. Dorn	(Son)	1934 White	Hall Road	White Ha	ıll,	Maryl	and 4	21161
	20a. Method of Disposition	20b. P	lace of Disposition (Name of empetery, crematory or other p	lace)	Date 2	20c. Loc	ation - City o	r Town, Stat	e
	1 Burial 2 Cremation 3 4 Donation	ecify) Gay	rison Forest	V.A. Cem.	4		Owning		ls, MD
	21. Signature of Funeral Service Lig	Figure 1 (1)	sher Duda-Ruc 7922 Wis	k Funeral e Ave. D	Home of undalk, M	Dun lary	dalk, land	Inc. 21222	
	23a. P Enter the disease, or co shock, or heart failure. List or		n. Do not enter the mode of o	ying, such as cardia	c or respiratory arre				imate I Between and Death
	Immediate Cause (Final disease or condition resulting in death)	a. A cute	myocarbi	u info	retion				8 ays
	1	Due to (or as a consequ	uence of):	b 4, 20				\ \	Suce
je.	if any, leading to immediate	b. Due to (or as a consequ	uence of):	KM1 L N	W 2 / W 2 K				5 9. 3
Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
	resulting in death) Last	Due to (or as a consequ	uence of):						
dica		d							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	I death 3 Ectopic pregna			2	3d. Date of de Month	elivery Day	Year
۳ ل	Part II. Other significant condition	s contributing to death but not resi	ulting in the underlying cause	given in Part I.	23e. Did tob	oacco us	se contribute	to the cause	of death?
od b	Severe s	emphysemo	\		1 🕱 Ye	s 2]No 3□ F	Probably	4 ☐ Unknown
plet	Left hi	lar lung n	~a \$ \$		24a. Was ar		24b. Were a	autopsy find	ings available of cause of
NO.	Demen	(T~			perforr	ned? 2 M No	death?	s 2 No	
Be (25. Was case referred to medical examiner?				ath (Check only on	e)			
ဝ	1 ☐ Yes 2 🕅 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DOA	other: 4 Nursing I	Home 5 ☐ Reside	ence 6	□Other (Sp	ecify)	
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day, Year) tion	Injury W	jury at ork? □Yes 2□No	28d. Describe ho	ow injury	occurred		
Medical Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ome, farm, street, factory, offic	е	28f. Location (St City or Town	reet and n, State)	f Number or F	Rural Route	Number,
dical		Physician: To the best of my know xaminer: On the basis of examina and manner stated.							use(s)
Me	29b. Signature and title of certifier		29c. Lice	nse number	2	9d. Date	signed (Mor	nth, Day, Ye	ar)
	> Tunh k	uddugan	MDD	80700	32	4	1191	12	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Year

2012

N/A

4c. County of Death

10g. Citizen of What Country?

United States

14. Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

821 NEWTAN ST # 308 Baltimore MD 2201

19

2:30

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🖾 No

Maryland

Registrar DHMH 17 Rev 1/2001

State

			For State Registrar	State of M	aryland		artment of F <i>tificate of E</i>		and M		giene Reg. No	201	2	1308	3 1
	Dhysicia	-/	1. Decedent's Name (First, Middle	, Last)						2. Date of Dea	ath Da	ay Year		3. Time of Death	
	Physicia Medic		TERRY	DIMARCO						April	22	201	2	10:40 P	M
-	Examin	er	4a. Facility Name (if not institution		h'm a	2.2	4b. City, Town, or				40	County of Dea	ath		
	Funeral		Sinai Hospit 5. Social Security Number		e (In yrs. last		Bau Hi If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birl		N/A	irthplac	e (State or Forei	gn
	Director		216-05-9779	1 □ M 2 🗓 F	93	Yrs.	Months Days	Hours	Min.	(Month, Da)			ountry)	MD	
	show d at		Usual Residence of Decedent 10a, State 10b, County			Town or Loc	ration			01/29/	191	9	10d	Inside City Limi	te
	arylan a-f sh fied a	Director	, and the state of										100.	1 Yes 2	
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Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	cy death 3	Ectopic pregnanc	CV.				23d. Date of c	delivery		
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	the H hin 24 the Fi	Me	only one) 3 🗌 Certifyin	Nurse Practitioner: To the			, death occurred at t	he time, dat			the caus	e(s) and manner	r as stat	ed.	4100
	5 wit		29b. Signature and title of certifie RMeWA				29c. License				29d. Da	ate signed (Mor	nth, Day	(, Year) 0/2	
			20 Name and address of person	who completed cause of a	death (Itom 9	23a) (Type 5	Print)			771.0	1 101	·Bolnie	do.	re Au	,
	3		Rutika Me	hta , Sina	ai M	ospit	al of re	Balti	mor	e, 240	ball	imore,	N	012 re Ane 1021219	5
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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4 Homicide determined (Specify) found at home Baltimore, MD. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)			1 Natural 5 Reading (Month, Day, Year)	1 Von		• •	
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O.C.M.E. April 19, 2012	FRES	Me				29d. Date signed (Mont	th, Day, Year)
20. Name and address of person who completed as use of death (New 20s)]	+total -tolling			April 19, 2012	
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223				,	Street, Baltimore, M	D 21223	
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar APR 2 6 2012	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6 2012	bares			

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			State Registrar	Certificate of Death	R	eg. No. 20	2 13083
ı	Physicia Medi		1. Decedent's Name (First, Middle, Last) Dillio Frank	Ferro	2. Date of Deat Month April		3. Time of Death 12 5:30 A M
CARTON CONTRACTOR	Examir	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
-			7605 Avondale Ave 5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Baltimore Co. thday) If Under 1 Year If Under 24 Hrs.		Baltimor	
la.	Funeral Director	П	216-10-0046 1MM2 DE	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry)
		1	Usual Residence of Decedent	Yrs.	Feb. 14	,1911 No	rth Carolina
	yland f sho ed at	ţċ	10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits
	Mar 28a-	iř	MD Baltimore Co.	Baltimore			1 🗌 Yes 2 🔀 No
	ith th	Funeral Director	10e. Street and Number 7605 Avondale Avenue	10f. Zip Code 21224	1	0g. Citizen of What Co	2.5
	ems (nue	11. Marital Status 12. Was Decedent Ever in U.S.		ecify Yes or No-	United Sta	
Baltimore, Maryland 21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, Whit	
15-(72 hor n "nat fedica	Completed	(Specify only highest grade completed)	. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	ing T	16b. Kind of Business Food Proce	
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nor	age 1 ent of nt: If it y or o		1X Burial 2 Cremation 3 Removal from State cemeter	ry, crematory or other place)		20c. Location - City or	
altin	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra		21. Signatur of Funeral Service Licens Pennis	awn Cemetery 4/24 22. Name and Address of Facility	/2012	Baltimore	e, Maryland
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			23a. Fart 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause ch line.	not enter the mode of ding, such as cardiac o	r re piratory arres	st,	Approximate Interval Between
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x 687	endin r use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death	n 3 🗆 Ectopic pregnancy		23d. Date of de	ivery
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Ž	Physic this c	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out 27. Manner of Death 288 Date of injury 285 Ti		me 5 Residen	nce 6 Other (Spec	ify)
0 0	ding fing finance.	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) in	ime of 28c. Injury at 28c. Injury at work? M 1 1 Yes 2 No	28d. Describe how	v injury occurred	
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	Voith Voith		29b. Signature and title of certifier	29c. License number		d. Date signed (Month	
			XXXX CO VIW	00011512		04-2	5-12
			30. Name and address (Liberson who completed cause of death (Item 23a) (T	Type, Print) 7. M D 1/0/05 M/-	2017	7 21	3 2 2
	Stat	е	31. Date filed (Month, Day, Year) APR 2 6 2012 32. Registrar's Signature	naves		10010	144
	Registra	ır	APR 20 2012 Denger P. A				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month | 5,50 AM Michiko Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Baltimore Washington Medical Center 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 495-68-0974 1 □ M 2 🛚 F January 15, 1949 63 Japan Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director notified 1 ☐ Yes 2X No Maryland Anne Arundel Hanover 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? event, the Medical Examiner must be 23a Funera 7681 Tuckerman Drive 21076 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced Specify: Japanese 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 은 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence. Hatsuju Maeda Misako Nishi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John William Frey, Jr./Husband 7681 Tuckerman Drive, Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State west Arundel Crematory 1 Burial 2 X Cremation 3 Removal from State April 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Erson M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VUS. disease or condition Medical resulting in death) as a consequence of): Examiner 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death be detached g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 ☑ No ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred medical B 26. Place of Death (Check only one) examiner? 2 1 No Inpatient 2 ER/Outpatient 3 DOA Other Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. Ineral Director: After this Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury 2 🗌 No filled in by the Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. Lice 30. Name and address of person who completed dause 0

State

Registrar

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)

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	Funeral	г	5. Social Security Nur	mber 6. S	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year	If Under		Date of Birt	h	9. Bi	rthplace (State or Foreign
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	/lanc f sho	ä	10a. State	10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits
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	a or		10e. Street and Numb	per				10f. Zip Code				10g. Citi	zen of What C	ountry?
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felipe Maryland	shou and is m		19a. Informant's Nam	ne/Relationship (7	Type, Print)		19b. Mailin	g Address (Street	and Numbe	r or Rural Ro	oute Number	; City or	Town, State, Zi	ip Code)
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<i>∱qŒY,</i> Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	ral 5 rvice Lic.n	see		132	Name and Addre	Fot Eacility	al Ho	me D	Ζ		
. m	o a E G) GR	SIL	/ M	00770		.3 Talbot					rvland	20707
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Box 68760	death certificate be executed re attending physician and ed for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was decedent pr	recoant	23c. If yes, outcome								Od Data of da	alis com c
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	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Me	only one) 3 L	Certifying Nurs	se Practitioner: To the	e best of m	ny knowledge,	death occurred at t	ne time, date	and place,	and due to th	e cause(s	and manner a	as stated.
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	29,		30. Name and address	s of person who	completed cause of de	eath (Item	23a) (Type, Pr	int) 0		0	2	. /	0.0	000
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20^{pay}2012^{ear} APRIL 8:15 EDWIN **GERARD** FOLEY ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE BALTIMORE TIMONIUM 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) 482-02-9434 **Director** 1 XM 2 □ F 03/05/1921 91 NEW YORK Usual Residence of Decedent or 28a-f show 10a, State 10c. City, Town or Location death with the Maryland **Funeral Director** 10d. Inside City Limits iral", or items 23a or 28a-f s Examiner must be notified BALTIMORE MD TIMONIUM 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 DULANEY VALLEY ROAD 21093 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 nand Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PRIEST CATHOLIC CHURCH Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ THOMAS FOLEY MARY GUINANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s
Department of Health a.
Important: If item 27 is
any injury or GERARD SZYMKOWIAK 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SACRED HEART OF JESUS 4/24/12 BALTIMORE, MARYLAND 21. Signature of Fundament vice Licensee Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 21224
700 S. CONKLING STREET, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic
5 Other (s in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying care gr 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Ves Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 4/19/2012 27. Manner of Death 1 Natural
Accident 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 No unwitnessed fall Investigation 6 Could not be 5a Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) STEIIA MANS 2300 DUIAWEY VAIIEY K 4 Homicide Neuman within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of cotifie 30. Name and add s of person who completed cause of eath (Item 23a) (Type, Print) DNP State Registrar

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920	within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	11. Marital Status 1	ed 2 Married	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	? /	11	Vas Deced f Yes, spec	ify Cubath	, Mexican,	in? (Spec Puerto F	ify Yes or No- ican, etc.)		- American Indian, k, White, etc. White	9
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altimore,	20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 3 Date Apr 13 4 Donation 5 Other (Specify) 20c. Location - City of Cernetery, crematory or other place) 4 Donation 5 Other (Specify) Beltsvil												City or Town, State	ryland	
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. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transiconness.		IF FEMALE; 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ g ☐ Unknown	onths?	3c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3 [Ectopic p Other (spe					23d. Date Mor	e of delivery th Day	Year
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Division of Vital Records,	I or Atter after dea Director	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In building, et	jury - At hom tc. (Specify)	ne, farm, stre				-	8f. Location (Str City or Town		or Rural Route Nu	nber,
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			Ki v Ma 31. Date filed (Month,	rce Kas	hi MI)	3020	Dur	dal	KH	VI.,	B4/1	D.Mel	21222	ζ	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2.20A Ethel May Green APZIL 2017 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or L 4c. County of Death BALTI MORE INLASHMIGTON MEDICAL CENTER GIEN BURNIE AMNE Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Months Days Hours (Month, Day, Year) **Director** 1 □ M 2 👿 F 220-30-6073 Usual Residence of Decedent Maryland Dec 17. or 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Prince George's 1 Yes 2 X No Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7810 Clark Road Lot C45 20794 USA and Mental Hygiene. is marked other than "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify 3 Widowed 4 X Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 11 0 nursing <u>healthcare</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwin Francis Hooper Agnes Elizabeth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i John Green/son 769 210th Street Pasadena, MD irfury or other 20a. Method of Disposition permi. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Signature of Funeral Service Ronal any iri 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Physician/ Onset and Death CEPEBROVASE ALLIDE disease or con Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trai Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number d cause of death (Item 23a) (Type, Print) alen Burnie mi) 20161

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Registrar's Signa

			For State	State of Ma	ryland /	Department of F Certificate of L			ne No. 2012	13089
			 Registrar Decedent's Name (First, Middle 	, Last)	7	00/11/10410 0.12		2. Date of Death	1000	3. Time of Death
	Physicia Medic		Thomas E	. Garner	•			Month 04 10	Day 2012	6:53P M
	Examin		4a. Facility Name (if not institution	, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Deat	
			7510 Newburg D 5. Social Security Number			Lanhan			Prince G	
	Funeral Director		428-16-0542 Usual Residence of Decedent	1 X M 2 F 90	(In yrs. last bir	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yes 02 14	1922 9. Bir	thplace (State or Foreign untry) MS
	and show	ъ	10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
	Maryla 8a-f : tified	Director	DC		Washi	ngton				1 😾 Yes 2 □ No
	the land		10e. Street and Number	-		10f. Zip Code		10g.	. Citizen of What Co	ountry?
	h with	Funeral	1232 Emerson S			20017		US	SA	
9036	filed within 72 hours after death with the Maryland tal Hygiene. Set of them 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Mari 3 □ Widowed 4 ☒ Divorced	If You Cive	er in U.S. _{Io} 1942– 982	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	an, Mexican, Puerto		14. Race - Ame Black, Whit Specify: B1	e, etc.
15-0	72 hou n "natu edica	Completed		nt's Education est grade completed)	16a	. Decedent's Usual Occup (Give kind of work done of		ing 16t	o. Kind of Business	Industry
12	within giene.	Son	Elementary/Seconday (0-12)	College (1-4 or 5+		life. DO NOT use retired) pervisor of	Records		Departmen	t of Defense
pu	filed within al Hygiene.		17. Father's Name (First, Middle, L	.ast)	100	.porvisor or		e (First, Middle, Maid		
/lar	should be file n and Mental F 7 is marked or raumatic ever	မှ	Thomas Garner				Katie Lo	owe		
lan	shoul and I is m		19a. Informant's Name/Relations		191	b. Mailing Address (Street	and Number or Rura	al Route Number, City	y or Town, State, Zi	p Code)
€, ₹	1 and 2 should be of Health and Ments fitem 27 is marked rother traumatic e		Coletta Garner	/Daughter		510 Newburg				
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If its any injury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	cemete	of Disposition (Name of ery, crematory or other place ton Cemetery	05/0	7/2012 Ar		Ά
Bal	permit Depar Impor any in		21. Signature of Funeral Service L	- //	Incom	22. Name and Addres		rshall-Mar ashington		
			23a Part 1. Enter the disease, or	complications that caused	the death. Do				, BC 2001	Approximate
عد	Physician/		shock, or heart failure. List o Immediate Cause (Final	•	. D					Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Metastat. Due to (or as a		state Cancer				
	Examiner	ř	Sequentially list conditions,	b. —						
	ed nsit	Examiner	if any, leading to immediate bause. Enter of denying Cause (Disease or iinjury	Due to (or as a	consequence	of):				
	death certificate be executed ne attending physician and ed for use as the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):				
09	ate be e ohysicia the buri	dical		d						<u> </u>
	tificat ng ph as th	Mec	IF FEMALE:							
Box 687	ith cer ittendi	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	Fetal deat	th 3 Ectopic pregnand 5 Other (specify)	ру		23d. Date of de Month	livery Day Year
B.	ires that the death certific signed by the attending i d be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time or death	5 🗆 Other (specify)				
P.O.	that the		Part II. Other significant condition	ons contributing to death bu	t not resulting	in the underlying cause give	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
JS,	uld be	ed b						1 🗆 Yes	2 🗆 No 3 🗆 P	Probably 4 Unknown
Sor	law require has been si je 2 should i	Completed by						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Rec	The la ate ha	Som						performed	l? death? ¶No 1 ☐ Ye	s 2 🗆 No
tal	ysician: is certific director,	Be (25. Was case referred to medical examiner?	Hospital:	1174		ace of Death (Check	k only one)	2/2	Daughtoria
fζ	Physic this c	은	1 Yes 2 X No 27. Manner of Death	1 Inpatie		utpatient 3 DOA Other	er: 4 Nursing Ho	ome 5 Residence	6 K Other (Spec	Daughter's
n 0	ding th. After funer	cate	1 Natural 5 Pendir 2 Accident Investi	ng (Month, Day,	Year)	injury work	y at (? Yes 2 🗆 No	28d. Describe how in	njury occurred	
isio	Atten r dear sctor: by the	Certificate;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Injur	y - At home, fa	arm, street, factory, office		28f. Location (Street		ıral Route Number,
Division of Vital Records,	Ital or Irs afte al Dire		L	building, etc.	(Specify)			City or Town, St	ate)	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of n Examiner: On the basis of ex Nurse Practioner: To the b	amination and/	or investigation, in my opinio	on, death occurred at	t the time, date and pl	ace, and due to the	cause(s) and manner stated.
	To t To 1		29b. Signature and title of certifier Tocely	ne Koua	tchou	29c. License	63748		Date signed (Mont. 4/12/2012	
+1			30. Name and address of person Jocelyne Kouat			(Type, Print) University	Pkwy, Bal	timore, M	D 21218	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature		-			
	Registr		APR 2 6 201	2 Chause	B. A	MELICA				
DHI	MH 17 Rev 7/20	U09								

			For State	State of Marylan		artment of H			0	010	12000
			Registrar 1. Decedent's Name (First, Middle, Last)		Cel	uncate of D		2. Date of Dea	Reg. No.	UIZ	3. Time of Death
	Physicia Medio		Marjorie Jean	Hanks				Month April	Day 23.	Year 2012	9:30 A M
	Examin		4a. Facility Name (if not institution, give str	reet and number)		4b. City, Town, or			4c. County	y of Death	
	-		Manor Care Rossville				timore			ltimor	
	Funeral Director		5. Social Security Number $196\text{-}14\text{-}8007$ $6.$ Sex	M 2 K F 7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			9. Birthp Coun	olace (State or Foreign try) PA
t.			Usual Residence of Decedent					10 10 17			
	yland -f sho ed at	ctor	10a. State 10b. County		, Town or Loc					1	0d. Inside City Limits
	r 28a notifi	Dire	Maryland N/A 10e. Street and Number		Baltimor	e 10f. Zip Code			10g. Citizen of	What Cour	1 ¥ Yes 2 □ No
	within 72 hours after death with the Maryland glene. ter than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	5926 Cedonia Avenue			7011 E.P 0000	212	206	Tog. Oilizeit of	USA	nt y :
	items er mu	Fun	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Vas Decedent of His Yes, specify Cuban	spanic Origin? (S	Specify Yes or No-		ce - Americ	
36	after c	l by	1 Never Married 2 Married	1 Yes 2 X No		Yes 2X No		no moan, etc.)	Specify	ck, White, 6 : Whit	
8	atura cal Ex	Completed	3 X Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates.	16a, Deced	ent's Usual Occupa	ition		16b, Kind of B		
215	e. Ban "n Medi	duic	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	(Give I	rind of work done du D NOT use retired)	uring most of we	orking	TOD, TAILE OF E	dolliego lite	adoti y
7	ygiene ygiene her th	Be Co	12	1	Homen	naker			Own I		
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Mi.lo George Shaw					ame (First, Middle, a W. Locke	Maiden Surnam	e)	
ary	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type	·		g Address (Street ar		Rural Route Number	; City or Town, S	State, Zip (Code)
Σ ش	ealth m 27		Mr. Gregory F. Hanks, St		J	Cedonia Ave	enue Bal	ltimore, Ma	-		
nore			20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3 ☐ R	amoval from State	emetery, cren	sition (Name of natory or other place vice Corpor	e) Pation Ma	Date -25-2012	20c. Location Towson, N	-	
alti.	permit. Page Department (Important: If any injury or		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus uneral Service Licensee	1111	22	Name and Address	s of Facility	5305 H	arford Ro	pad	
m	a limit de la		half-Min	1		onard J. Ru			ore, Mary	land 2	21214
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ente	r the mode of dying	, such as cardia	c or respiratory arr	est,		Approximate interval Between
-	Medical		Immediate Cause (Final disease or condition resulting in death)	Commany	Arti	y Dise	ne			_	Onset and Death
Mary Services	Examiner			Due to (or as a consult	ence of):	noon					
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Эна to (этав а сопесци	ence of:		r · 0				
	ecuted and transit	Examiner	Cause (Disease or linjury that initiated events c. resulting in death) Last	Due to (or as a consequ	wc	Heart	taun	<			
	ate be executed hysician and the burial-transit	dical E	resulting in death) Last	Strial	1 56	Heart	~				
3760	ficate g physas the	Jedi					F 1				
x 687	h certifica tending pl r use as t	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths?	c. If yes, outcome of pregnar		Ectopic pregnancy	/			ate of delive	•
Box	requires that the death certificat been signed by the attending ph should be detached for use as th	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5	Other (specify)			Mo	onth	Day Year
P.O.	requires that the been signed by the should be detach	by Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
S,	uires t in sign uld be							1 🗆 ۱	∕es 2 □ No	3 🗆 Prot	oably 4 Unknown
S	2 S S	Completed						24a. Was a			osy findings available mpletion of cause of
ğ	The ate pag	Con							rmed?	death?	2 🗆 No
ıta	i cian : The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:		Othor	ce of Death (Ch				
<u>></u>	Phys r this eral dii	e: 10	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	t 3 DOA 28c. Injury	4 Mursing	Home 5 Resid)
ou	ath. r: Afte	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	injury	M 1 □ 1	Yes 2 No		, ,		
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,
ā	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier Tocertifying Physic	an: To the best of my knowle	edge, death o	ccured at the time,	date and place,	and due to the cau	ise(s) and mann	er as state	d.
	the Ho lin 24 h he Ful hpleted	Medical	(Check 2 Medical Examine	r: On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinior	n, death occurred	d at the time, date a	nd place, and du	e to the cau	use(s) and manner stated.
	Vith Con		29b. Signature and title of certifier	10-2	24.0	29c, License			29d. Date signe		
			20 Name and address of		23a) (Tupe P		31464		412	4/12	_
			30. Name and address of person who con SHOA(13 A HA.	STANIMD &	2(N.	Sutan S	St. 8	inte 300	, BAL	rimon	ZE MD 21201
	Stat		31. Date filed (Month, Day, Year)	320Registrar's Signat	ure	Eutan S	1				
	Registra	ar	APR 2 6 2012	Alexan A	1. 100	Kar					

DHMH 17 Rev 7/2009

Daniel Victor Hor		1- For State Certificate of Death	lygien	e Reg. I		12	1309
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Daniel Victor Horvath	Mont	of Death	ev Year		e of Death 33 hrs
6		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3552 Bladensburg Road College Park	h		4c. County of Prince Ge		
Funeral Director		5. Social Security Number 193–38–1528 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Mir		e of Birth(N	им/DD/YYYY 18	9. Birthplace Foreign Country)	(State or PA
		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			_	10d. lr	nside City Limits
and show any occ.	į.	MD Anne Arundel Glen Burnie				1 🗌	Yes 2 No
the Maryli Sa nr 28a-f	Director	10e. Street and Number 1340 Aster Drive 21061			Citizen of Wha	U	SA
ter death with ", nr items 2:	Funera	11. Marital Status 1 XXNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? Army 2 No 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 14. Yes 2 XXNo specify:			14. Race - White, Specify:	American Ind etc. Whi	
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 15. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret Printer					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Stephen Horvath	ie (First, M Marga			kie	
MD 21; d 2 should to the and Men m 27 is mar	٥	19a. Informant's Name/Relationship (Type, Print) Nicole S. Horvath / Daughter 19b. Mailing Address (Street and Number or 1708 Liberty Street)	Rural Route Number, City or Town, State, Zip Code) t, Erie PA 16502				
Slan Flea Fite		20a. Method of Disposition 1 Burial 2 KCremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory 4/1	Date 26/12		Oc. Location - 0 Hanove		
Baltimo permit. Page Department o Important: injury ar att		21. Sign fure of Funeral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens 1501 E. Fort Avenu	e, B	altım	ore MD	21230	
Physician /// /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respira	itory arrest,	shock, or hear	t Appr Betv	oximate Interval veen Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):				_	Deasi
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
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6876C ertificate ding phys	an/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregn 4 Pregnant at time of death 5 Other (Specify)	nancy		23d. Date of o Month	delivery Day	Year
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s, P.O. irres that the signed by I be detach	ρ	Fatt II. Outer digital containers Contained in a container containing to declar but not containing in a container co	· L			4 V Unknown	
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tal Rection: The certificate		25. Was case referred to medical 26 Place of Death (Check					
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on of Vit nding Physic th. r: After this	\vdash	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. De	escribe hov	v injury occurre	d	-
Division of Vital Records, pital or Attending Physician: The law requir ours after death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should the control of the control	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.		cation (Stre Town, State		r or Rural Rou	ite Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place of the control one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to t	the cause(s	and manner and du	as stated. ie to the cause	∂ (s)
	Me	29b. Signature and title of certifier O.C.M.E.			9d. Date signe April 24, 20	•	y, Year)
5 sm		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 2	21223				
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Regis	trar	APR 2 8 2012 James A. Jacks					

	State of Maryland / Department of Health and Mental Hygiene														
			Registrar 1. Decedent's Name (First, Middle, L		Centitica	rtificate of Death 2. Date of I					012	13092 3. Time of Death			
	Physicia Medi		Joyce L. Herndon							April 1	24 ^{Day}	2012°	6:28 p. M		
	Examir	ner	4a. Facility Name (if not institution, ga Gilchrist Hospice		I	4b. City, Town, or Location of Death Towson					4c. County of Death Baltimore				
	Funeral Director		5. Social Security Number 6. 216-52-5682 Usual Residence of Decedent	Sex 7. Age 1 □ M 2 🖾 F	(In yrs. last birth		If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. 1 (Months 1)								
	Aaryland 8a-f show tified at	Director	10a. State 10b. County n/a		10c. City, Town	or Location						1	0d. Inside City Limits 1 Yes 2 No		
	ith the N 23a or 2 st be no	ral Di	10e. Street and Number 41.33 W. Rogers Ave	7710	_	10f.	Zip Code	15			10g. Citizer	n of What Cour	itry?		
	eath w	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was De			in? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Americ	an Indian,		
9000	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural" are most be notified at matic event, the Medical Examiner must be notified at	β	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 24 No f Yes, Give			Specify:	Puerto I	Rican, etc.)		an-American			
Maryland 21215-0036	vithin 72 ho iene. r than "na the Medic	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th			Decedent's U Give kind of the DO NOT Technic	work done du use retired)		of workir	ng	16b. Kind of Business/Industry Polk Audio				
land 2	should be filed within 7 n and Mental Hygiene. 7 is marked other than raumatic event, the M	To Be	17. Father's Name (First, Middle, Las	,			18. Mother's Name (First, Middle, Maiden Surna. Gladys Byrd								
, Man	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es		19a. Informant's Name/Relationship Carlos Herndon Sr./	(Type, Print) Husband	19b. 4 1	Mailing Addr 33 W. R	ess (Street an	venue,	or Rural Balt	Route Number	nber, City or Town, State, Zip Code) MD 21215				
Baltimore,	Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposition 1 Mathematical Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		20b. Place of cemetery Woodlaw	, crematory c 1 Cemet e	r other place) LY		5 - 3 - 2		Woodla	ion - City or To MD			
Balt	permit Depart Import any inj		21. Signature of A neral of A ice Lice	ins e						e Funera 11stown,			Peltimore Co.		
	Physicism/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bett												
	Medical Examiner		disease or condition resulting in death)	a	Due to (or as a consequence of):										
N		iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	Due to (or as a consequence oi).										
	ate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):												
09,	cate be e physicia s the bur	edical		d											
. Box 687	death certifi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 goorths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death	3 Ectop					23d	. Date of delive	ry Day Year		
P.0	s that th gned by be detac	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in	the underlyin	g cause giver	n in Part I.		23e. Did to	bacco use o	bacco use contribute to the cause of death?			
ords,	require been si should I	leted								1 🗆 '	Yes 2 N		ably 4 Unknown		
Reco	The law cate has page 2	Completed								autor	rmed?	prior to cor death? 1 \(\sum \) Yes	npletion of cause of		
/ital	sician: certific) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Other	e of Death					1		
Division of Vital Records, P.O.	nding Phy ath. :: After this ie funeral d	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of injury (Month, Day,	t 2 ER/Outp 28b, Tir Year) inj		28c. Injury a work?	ıt	2	ne 5 Resid	7	Other (Specify) curred	nospice		
Divisio	al or Attendii s after death. Il Director: Ai ed in by the fu	Certificate:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injury	lace of Injury - At home, farm, street, factory, office 28f. Location						on (Street and Number or Rural Route Number, Town, State)				
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	(Check 2/ Medical Examonly one) 3 ☐ Certifying Nu	ysician: To the best of miner: On the basis of exaurse Practitioner: To the basis	mination and/or i	nvestigation,	in my opinion,	death occi	urred at t	he time, date a	nd place, and	due to the cau	se(s) and manner stated.		
	vitt O		29b. Signature and title of certifier	lus		ŀ	9c. License n	-O2	03			gned (Month, E			
	D 1		30. Name and address of person who	CHARLES	th (Item 23a) (Ty	pe, Print) うしい I	J. C	ront	es	ST TO	Mich	25 Z			
3	Stat Registra	e ir	31. Date filed (Month, Day, Year), APR 2 6 20	32. Registrar's	Signature	tarke	,			_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month PM Physician/ 11:11 2017 les rone nr. Medical 4c, County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Park Adventist lakoma ontgomery Hospita ashinaton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min. Country) 1 🕅 M 2 □ F Washington Director Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland rartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Funeral Director 1 Yes 2 No Alexandria Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. 2 🗶 No ģ 1 Mever Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fairfax Lo. Schools Attendant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Barbara Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State Alexandria, Virginia 2012 othel emeteri 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Signature of Funeral Service Licenses 22, Name and Addres of Facility (h) 00 B any Robert Da 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysiciani Pumnar H
Due to (or as a consequence of disease or condition resulting in death) Medical Examiner hronic Saquectieth list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month in the past 12 months? Day Pregnant at time of death should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Congestive peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Mellitus Diabetes autopsy has page 2 performed' 1 Yes 2 No Dyslipidemia 2 this certificate 25. Was case referred to medical examiner?

1. Yes 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, Hospital: Other: ٩ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 = 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Oirector; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar

DHMH 17 Rev 7/2009

Takoma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600

Ho.

George

2012

Marylano

William Leroy Jo		State of	r Print in Black if of Maryland / Depa Ce		Health an		łygiene	201	2 309
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat Month April 23, 2	h	3. Time of Death 2125 hrs				
parties.		4a. Facility Name (if not institution, give	William Leroy street and number)			Location of Deat		4c. County of Death N/A	1
Funeral Director			7. Age (In yrs. 146	last birthday) Yrs.	If Under 1 Yea Months Day		-	Eoreio	thplace (State or in untry) MD
yland 1-f show any 100Ce.	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number	10c. City	y, Town or Locati Baltimor			110	og. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No
c death with the Maryland or items 23a or 28a-f show must be notified at once.	I Director	4221 Hickory Avenue			21	211		U.S.A.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		or Dates:	1	es, specify Cubar	n, Mexican, Puerto		White, etc. Whit Specify:	
1036 rithin 72 hours one. or than "natur	mpleted	15. Decedent's Education (Specify online Elementary/Secondary (0-12)	y highest grade completed) College (1-4 or 5+) +]			tion (Give kind of b. DO NOT use re	tired)	16b. Kind of Business/I	
215-0 be filed w ntal Hygie rked othe ent, the N	Be Co	17. Father's Name (First, Middle, Last) William Leroy Jones,	Sr.				e (First, Middle, M ra Menikhei	•	
MD 21 2 should I h and Mer 27 is man	٩	19a. Informant's Name/Relationship (Ty Sandra Jones (Mother)		1	•		. C Balto	ber, City or Town, State D, MD 21211	
nore, lages I and nt of Healint: If item other tra		20a. Method of Disposition 1 Buriat 2 MCCremation 3	Removal from State	Place of Disposic crematory or oth Lantic Cr	er place)	•	Date 1/26/12	20c. Location - City or Glen Burnie,	
Baltin permit. P Departme Importan injury or	ł	4 Donation 5 Other Specify: 21. Signature of Funeral Service Dicens	ee		ame and Addres		rgee Henss to, MD 21	s-Seitz Funera 1211	1 Home, Inc.
Physician ////////////////////////////////////		23a. Par I. Enter the disease, or a failure. List only one cause on each				such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner			oue to (or as a consequence of		omo iicat	ca by ros	, it i ona i	Азрпуата	
d sit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	oue to (or as a consequence of			_			
e executed cian and rial - transit	Sal	d. X UNPENDED	AMENDED Item#1 a	as noted	,23a,27,	28a-f,pe	er me,g9	27 5-9-12 sm	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fet	al death 3 ner (Specify)	Ectopic pregn	ancy	23d. Date of delivery Month D	day Year
cords, P.O. B law requires that the d has been signed by the	<u>a</u>	Part II. Other significant conditions	contributing to death but not r	resulting in the u	nderlying cause (given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records, tal or Attending Physician: The law requirers after death. 11 Director: After this certificate has been sited in by the finneral director, page 2 should be	Completed						24a. Was a autops perform	sy prior to c m <u>ed</u> ? death?	topsy findings available ompletion of cause of
Vital Rec hysician: The I this certificate I	o Be C	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient		of Death (Check Other Nursi		Residence 6 🗸 Other	: Scene
sion of \\ .ttending Phy death. ctor: After th	-	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year) fd 4-20-12	28b. Time of Ir	L pm	ry at Work? Yes 2 X No	subject intoxic		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physicia		nd:Resid	ence		C Balt	imore,MD.	ral Route Number, City KOTY Ave. Apt
To the H. within 24 To the Fo completed	adica	one) 2 Medical Examiner:	On the basis of examination a and manner stated.		ion, in my opinior	, death occurred		and place, and due to the	cause(s)
	Σ	29b. Signature and title of certifier			29c. Licens O.C.			29d. Date signed <i>(Mor</i> April 24, 2012	im, Day, Year)
0		30. Name and address of person who co Ling Li, MD Assistant Me	ompleted cause of death (Iten edical Examiner 900		e Street, Bal	timore, MD 2	1223		
St Regist	e cc	31. Date filed (Month; Dey) Year)	32. Regular's Signat	ture					

ORIGINAL

ConE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13095 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Apri Phyllis Ann Janus Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Days **Director** 385-34-7180 1 □ M 2 🗓 F 75 Aug. 14, 1936 Michigan or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Mariant. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Birdcherry Lane 20707 USA 7311 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 2X No Yes, Give 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edmund Beauchamp Anna Morin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Conrad L. Janus/Husband 7311 Birdcherry Lane, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/25/2012 Resurrection Cem. Clinton, MD 22. Name and Address of Facility . Signature of Funeral Service Licenses Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Pause (Final Onset and Death Myocardial Ph, sician/ Infarction disease or condition resulting in death) min. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 KER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Accident
Suicide 2 🗌 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 2 Medical Examiner: On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 22966

6 m

Thomas H.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar Laurel Regional Hospital

Laurel,

Emergency

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Rd.

32. Registrar's Signature

Burquieres, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 13096 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>12</u> Physician/ Vincent Keenan April 24. 5:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A Baltimore City St. Joseph Manor If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 108-18-2941 Hours **Director** 1 🗙 M 2 🗆 F 86 June 27, 1925 New York Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f XX Yes 2 No Maryland Baltimore N:A ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 21210 USA 911 W. Lake Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. White 1 X Never Married 2 Married ģ Yes Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Church Roman Catholic Priest Be 17. Father's Name (First, MIQUIE, Lacy)
Thomas James Keenan 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth C'Shaughnessy 9a. Informant's Name/Relationship (Type, Print) Fellow St. Joseph Society of the Priest Sacred Heart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert Street Baltimore Maryland 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) New Cathedral Cemetery 4/28/12 Baltimore Maryland of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Baltimore, MD Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final On t and Death Physician/ disease or condition resulting in death) HEART -ONGESTIUE Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing indeeth) least Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Day Year Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Wiknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 140 Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Pesidence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Μ 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar

DHMH 37 Rev 06-2011

State

me 1

John T. Evelius, M.D.

APR 2 6 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Osler Drive Suite 308 Towson, Maryland 21204

D0034952

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Dolores Kegel 6:15 AM 2012 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Multimedical Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) Funeral 1 ☐ M 2**X** F Months Days Hours 08/27/14920 219-12-8723 91 Yrs MARYLAND Director Usual Residence of Decedent or 28a-f shov items 23a or 28a-f shorer must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2 X No NOTTINGHAM MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 U.S.A. 9227 SEVEN COURTS DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3x Widowed 4 □ Divorced Specify: "natural", Completed WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) the DOMESTIC HOUSEWIFE traumatic event, Be permit, Page 1 and 2 should be filed. Department of Health and Mental H-Important; If item 27 is more any injury or others. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **BERTHA** KEUSCH PETER WOYTOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9227 SEVEN COURTS DR., NOTTINGHAM, MD 21236 REGIS KEGEL/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State SACRED HEART OF JESUS 4/25/12BALTIMORE, MD Donation 5 Other (Specify) 21. Signature of Funer TILLY & TETTER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death
4-18-2012 Immediate Cause (Final Physician. Acute Stroke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner sided Pneumonia 4-17-2012 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner two Diabetes Mellitus Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Law the control of the contro 1ears that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hyperlipidemia lear 5 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertension Atherosclerotic Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Recurrent breast cancer on left 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Ecertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie (Lorel 23, 2012 R097104

Registrar DHMH 17 Rev 7/2009 senesis Multimedical Center 7700 York Road Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Kale

26

Michelle 31. Date filed (Month, Day, Year)

			State of Mary		artment of F		lental Hygi	ene				
			1 - State Registrar	Re	g. No. 20 2	2 13098						
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	27			2. Date of Death Month APRIL	22°, 2012	3. Time of Death			
	Medic Examin		STANLEY KAUFMA 4a. Facility Name (if not institution, give street and number)	N.	4h City Town or	Location of Death	APRIL	4c. County of Death	3:20 PM			
	Exami	er	GILCHRIST HOSPICE CARE		TOW			BALTI				
	Funeral			yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign ntry)			
	Director		215-12-4068 1 ☒ M 2 ☐ F Usual Residence of Decedent	89 Yrs.	Widitins Days	110dis IVIIII.	03/30/1		MD			
	and show at	or	Ostal Residence of Decedent	Oc. City, Town or Lo	cation		,,		10d. Inside City Limits			
	Maryla 28a-f	Director	MD N/A	BALT	IMORE				1 🔀 Yes 2 □ No			
	a or 2		10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	untry?			
	th with ms 23 must	Funeral	6317 PARK HEIGHTS AVENUE, #		212			USA				
(0	or iter	by Fu	11. Marital Status 1 □ Never Married 2 🗶 Married 1 □ Never Married 2 🗶 Married 1 □ Never Married 2 🛣 Married	r in U.S. 13. \	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	city Yes or No- Rican, etc.)	14. Race - Ameri Black, White,				
99	ıral", IExar	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No	Specify:		Specify: WH	ITE			
5-0	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done d	ation Juring most of worki	ng 1	6b. Kind of Business/Ir	ndustry			
12	thin 7 ene. than he Me	Som	Elementary/Secondary (0-12) College (1-4 or 5+)	life. D	O NOT use retired) TOMOBILE	-		AUTOMOTIVE				
<u>ნ</u>	led w other ent, t	Be	17. Father's Name (First, Middle, Last)	710.	TOTOBLE	18. Mother's Name	e (First, Middle, Ma		TIVE			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	٦	MORRIS KAUFM	IAN		NETTIE		M	INNER			
lan,	should and it is me	V 74	19a. Informant's Name/Relationship (Type, Print)	- 1	-			City or Town, State, Zip				
	and 2 Health em 27 ther tr		LEATRICE KAUFMAN/WIFE 20a. Method of Disposition					-	E, MD 21215			
nor	Page 1 ment of I ant: If its ury or o		1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo cemetery, crer ARI TNCTO	natory or other place	e) !		Oc. Location - City or T				
Baltimore,	サモモラ		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	AMUNO CI	CHIZUK EMETERY 2. Name and Addres	104 / 24 is of Facility COT	/2012 LEVINGO	BALTIMOR N & BROS.,				
m	Depar Impor any ir		Mass Ce					ESVILLE, M				
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying	g, such as cardiac c	r respiratory arrest	,	Approximate Interval Between			
7	hysician/	9 19	Immediate Cause (Final disease or condition and a securities in death)	nal	Sail	ure, C	hronic	end-stan	Onset and Death			
A.	Medical Examiner		resulting in death) Due to (or a, a co	onsequence of):		,			1,000			
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	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									
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289	eath certificate attending phys	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of p					23d. Date of deliv	verv			
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		d by	Caron my Arter	dise	andenying cause giv	en in raiti.		cco use contribute to t	obably 4 Unknown			
Örd	law requires nas been sign e 2 should b	lete					24a. Was an		opsy findings available			
ecc	The law ate has page 2	Completed					autopsy performe	prior to co	ompletion of cause of			
a	sician: The law r certificate has b lirector, page 2 s	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Check	1 Yes 2	No 1 ☐ Yes	2 NO			
<u> </u>	hysic this ce al dire	P.	1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatier		r: 4 Nursing Ho	me 5 Residen	ce 6 Other (Specif	pece			
n 0	ding F h. After 1 funer	ate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Ye	ear) 28b. Time of injury	work		28d. Describe how	injury occurred				
SIO	Atten	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	At home, farm, stre			28f, Location (Stre	et and Number or Rura	al Route Number.			
Division of Vital Records,	al or safte											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam	knowledge, death on the contraction and/or investigation and/or investigation and/or investigation and the contraction and the	occurred at the time	, date and place, ar	nd due to the cause	e(s) and manner as sta	ted.			
	o the lithin 2 the lo the lo the lo the lo the lo the lo lo the lo	Me	only one) 3 Certifying Nurse Practitioner: To the be	est of my knowledge,	, death occurred at the 29c. License	ne time, date and pla	ce, and due to the	cause(s) and manner as	stated.			
	⊢≶⊨ŏ		1 A brothan lu	Cez , un			- 290	April 25	2, 2012			
	CF /		30. Name and address of person who completed cause of death	n (Item 23a) (Type, F	Print)	100	n C.	001	2, 2012 and 2120x			
	2		W. H. Kiley GAR		701 M	. Charl	ces St.	Dalk.	and size			
	Stat Registra		31. Date filed (Month, Day, Year) APR 2 2012	Signature-	KN							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year PM 2311 **Physician** 2012 Apr 20 4a. Facility Name (If not institution, give street and number) LUCAS, /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months 218-84-1963 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Directo ND more 10g. Citizen of What Country? 10f. Zip 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eve in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ✓ No Baltimore, Maryland 21215-0036 à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ondominiu nanc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ter 19a. Informani's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 is any injury or other trau once, Broening Baito, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee me and Add 221 or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Infarction mocardial Probable minutes Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated event) Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No been signed by the a Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 2 No Yes 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 1 X Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 \sum Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, eral Director; After this filled in by the funeral di within 24 hours a

Registrar

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifier

Panth Hawin 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 6 2012 racker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

21,2012

8

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-0061115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Le Kites Physician/ Month arch nciel 5:00 AM eron. (4 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 14 yterian Home of Maryland TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours **Director** 1 M 2 F Yrs Mar 20, 1923 New Jersey 88 "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 230 cm any injury or other traumatic event, the Modifier. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 USA 912 Southerly Road #1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married white 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucy LaSala Angelo Pask Coggiano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David LeKites/stepson 3507 Jarrettsville Pike Monkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 25tented AdmentofryiibBoard 655 W. Baltimore Street Runeral few Lice & d rector Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Seuse (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 \(\text{Yes} မ 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 29b. Signature and title of certifier 037016 April 18, 2012

State Registrar

31. Date filed (Month, Day, Year)

APR 2 6 2012

DHMH 17 Rev 06-2011

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth M. Greene, MD 6701 N. Charles St., Si. te 4104 Baltimore, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LISA 1:20a WILLIAM FRANCIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** nKlin Squa 1+imor 5 Social Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min NEW JERSEY ^h1^{Day},/ Director 148-26-4888 1934 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 FORE COURT 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3. ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER PEPSI CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. မ JOSEPH LISA VERONICA MORAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 CRISFIELD ROAD, CHASE, MARYLAND 21220 DEBRA HOPP/ DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 4/23/12 BALTIMORE, MARYLAND 21. Signature of Fundament e Licensee Name and Address of Facility
ILLY & ZEILER
901 EASTERN A INC FUNERAL HOME BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ension, 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, pagr 2 No 2 1 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettiying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0063327 04/22/2012 Pairm H. WOLDEHINGT

Registrar
DHMH 17 Rev 7/2009

State

9000 Franklin Square

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death cedent's Name (First, Midgle, Last) 2. Date of Death Mont Day Physician/ 2:02 AM April 23 2013 Medical Town, or Location of Death not institution, give st **Examiner** 4c. County of Death Memoria 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** If Under 24 Hrs. Min. 1 M 2 D F **Director** or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at **Funeral Director** 1 Yes 2 □ No 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Driver Be r's Name (First, Middle, Last) ည permit. Page 1 and 2 sh.
Department of Health an.
Important: If item 27 is m.
any injury or other Rural Route Number, City or Town, State, Zip Code) *3903* Guynn Oak, MD 2/207 20b. Place of Disposition (Name o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signatur Funeral Servi e Lice To Fredhilton Pass Balto. Mo 21229 yer the disease, or complications that caused the death. Do not enter the mode of dying heart failure. List only one cause on each line. Interval Between Immediate dause (Final Onset and Death Physician/ Hodomina disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed YIC and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Onset Seizure - CVA 1 Yes 2 No 3 Probably 4 Unknown Nonsustained Vtrach-ACT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate has 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066212 April 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Any McClosky 31. Date filed (Month, Day, Year) 201 East University Parkway, Battimore, Maryland 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ April 24,2012 8:02p M Teruko McNaul Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 9010 Briarcroft Lane Laurel Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Month, Day, Year) Aug. 15, 1925 Davs Hours Director 247-62-4403 1 □ M 2 🕅 F 86 Yrs. Japan Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 ☐ Yes 2🏋 No Maryland Prince Georges Laurel 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9010 Briarcroft Lane 20708 Japan or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Japanese 'natural", 3X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker <u>Own Home</u> Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ၉ Yakichi Mathushita Sakae Tokutome . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leslie Plater/caregiver |15407 Malaya Place Laurel,Maryland 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory,Inc. |04/25/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc re of Funer Service Licensee Stephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Acute Lymphoid Leukemia disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): the burial-transit Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | d be def δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 😾 No 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 T Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pendina Accident Investigation within 24 hours after death

To the Funeral Director: A

completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

DHMH 17 Rev 06-2011

29a. Certifier

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2 6 2012

Jocelyne Kouerchou, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jocelyne Kouatchou, MD. 4041 Powder Mill Road, Suite 600, Calverton, MD. 20705

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

163748

April 25,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ MINACLE MUSE 12:18 AM 2012 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTMONE BAUTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 45^{Min.} (Month, Day, Year) pr 12, 2012 Months 1 M 2 7 F Hours infant Maryland Apr **Director** Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ty□ Yes 2 □ No MD Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 4914 Brookwood Road 21225 USA items ? 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married 0 δ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give black "natural", 3 Widowed 4 Divorced Completed Year or Dates. or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) infant infant infant infant and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ဂ္ Selena Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau University of MD Medical Ctr 22 S. Greene Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🗓 Other (Specify) in state Signature of Luneral Service Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause Final disease or conditions. Approximate Interval Between Onset and Death AROID RESPIRATORY Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** RECURREN Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and-trans that initiated events resulting in death) Last Due to (or as a consequence of) -purialng physician as the burial-/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: ase a Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Pregnant at time of death Other (specify) the g Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performe Hospital or Attending Physician: The certificate 2 UNO 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 1 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 5 Pending Natural work? 1 🔲 Yes 2 🗌 No ☐ Accident ☐ Suici**d**e s after death | Director: / d in by the f Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nuise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of cert 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR 2 6 2012

DHMH 17 Rev 7/2009

29.5 GRene

30. Name and address of persol who completed cause of death (Item 23a) (Type, Print)

72849

St. Suite 65110 Baltimore

Adam Daniel Metz, I	 1- For		ate of Ma	aryland / D	Depar Certi	tment of ificate of	Health Death	and	Menta	al Hyg		g. No.	201	2 3 0	
	Deniet										Date of Death	n Dav	Year	3. Time of Death	
Medical Examiner		Adam Daniel Metz, II									April 23, 20	012		0807 hrs	
	4a. F	ecility Name (if not institution	on, give street a	and number)			4b. City, To Phoení	b. City, Town, or Location of Death					4c. County of Death Baltimore County		
	Poplar Hill Road and Warren Road 5. Social Security Number 6. Sex 7. Age (In yrs. I					t hirthday)	If Under		If Under 2	24Hrs.	8. Date of Birt		YYYY) 9. Bir	thplace (State or	
Funeral Director		cial Security Number	1				Months	Days	Hours	Min	April		Foreig	ountry) WV	
Director		2-76-4696 Residence of Decedent	1X M 2		65) 113	1	J			April	22, 1	277		
ROY	10a. S			10	c. City, T	own or Locat	ion							10d. Inside City Limits 1 Yes 2 X No	
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eath with the Maryland items 23a or 28a-f show ust be notified at occ.	ŀ	10113 Dave	ntry Dr			1	<u></u>	210		-2 / Cass	ifu Voe or No.		SA Race - Amei	rican Indian, Black,	
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B, N and 2 lealth item 2 traus	20a.	Method of Disposition				lace of Dispo	sition (Nam	e of cerr	netery,	Apr	Date i1 25,	20c. Loc	ation - City o	r Town, State	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importatot: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at soste To Be Completed by Funeral Director	21. 8	Signature of Funeral Service	e Lice Isee	11		22. T. O.	Name and	Address	of Facility	Home	of Du	laney	Valle	y, Inc. 21093	
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/Medical Examiner		ediate Cause (Final disea andition resulting in death)		oral Gunsho											
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Division of Vital Records, P.O. Box 68760, rother Hopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit contributed for the physician physician physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit contact of the physician physic	IF F	EMALE:		. If yes, outcome	e of pregi			3	Ectonic	pregnan	ncv		Date of delive onth	ery Day Year	
687 certific ading se as t	230.	Was decedent pregnant in past 12 months?	1 4	Live birth Pregnant at ti	me of de		etal death Other (Spec		Letopic	program	ioy			•	
Box 68760, e death certificate b the attending physical for use as the buth west clan/Me	1]	_	Unknown										to the squae of death?	
cords, P.O. Box law requires that the death has been signed by the att 2 should be detached for		II. Other significant con	ditions contri	buting to death	but not re	esulting in the	underlying	cause (given in Pa	irt I.				to the cause of death?	
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Records, The law requires ficate has been signage 2 should be											auto		prior to death	o completion of cause of	
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Division of Vital Records, putal or Atteodiog Physician: The law requirements after death. The law requirement of the control	3 6 4		ould not be	(Specify) Wo						\	or Town, Poplar Hill R	oad and	Warren Ro	ad, Phoenix, MD	
Hospit A hour		Cortifier -	Physician: T	o the best of my	knowled	dge, death occ	curred at the	e time, d	late and pla	ace, and	due to the car	use(s) and	manner as s	tated.	
Division To the Hospital or Attreed within 24 hours after death to the Funeral Director: completely filled in by the i	one	con only	xaminer:On th	ne basis of exan manner stated.	nination a	and/or investi	gation, in m	y opinio	n, death od	courred a	t the time, dat	e and plac	e, and due to	Month, Day, Year)	
290, Signature and title of certifier									1	24, 2012	vionin, Day, rear)				
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axiv	30.	Name and address of per	son who compl	eted cause of deal Examiner	eath (Iter	n 23a)	ore Stro	et Ra	ltimore	MD 21	223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 20b per fh g926 4-26-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Morris Physician/ : 25 AM ADG Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center ron OL Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. Months Days Hours (Month Day, 1 M 2 F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequer ce of): Examiner ear Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical vision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes ဂ္ဂ 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death the funeral 28b. Time of 28c. Injury at work?
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3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Q ___ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 3 ___ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RNP RO86520 empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person **4**ho 6095 Marchalle

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Mo

26

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G926 4/26/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Apri Physician/ 10:15PM 2012 OKUN WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Hospital rince (seorge's Laurel Laurel 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) Director 088-12-7587 1 🛛 M 2 🗆 F 93 07/31/1918 IN Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location death with the Maryland Director 1 Yes 2 X No MONTGOMERY SILVER SPRING MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? items 23a or ner must be n 0 Funeral USA 3118 GRACEFIELD ROAD, #CC112 20904 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. ıral", or iter I Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 X Widowed 4 Divorced WHITE Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) HIGH SCHOOL TEACHER EDUCATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ALTSCHULER ATTSCHULER OKUN **ESTHER** BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 BROAD BRANCH ROAD NW, WASHINGTON, DC 20015 ROBERT OKUN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 04/25/2012 REISTERSTOWN, MD 4 Donation 5 Other (Specify) BALTIMORE HEBREW Signal ur v of Fune al Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Infarction - Physician Myocardial hour disease or condition Medical resulting in death) (or as a consequence of) Due t Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Dav Pregnant at time of death be detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 은 1 🗌 Inpatient 2 🗶 ER/Outpatient 3 🗌 DOA After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending after death. 1 Yes 2 No Investigation 6 Could not be 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c License number 2 9 6 6 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7300 Van Dusen aurel, MD 30. Name and address of person who completed cauts of death (Item 23a) (Type, Print) Rd. Regional Hospita Burguieres, M.D. aurel Emergency Н. Thomas 31. Date filed (Month, Day, Year) State APR 2 6 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PASCAL 2014 KELVIN 20 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore MD Medical If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 071-60-6446 **Director** 04-28-1962 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland attended to Health and Mertal Hygiene. Assurant of Health and Mertal Hygiene. Ordertt if feem 27 is an anaked other than "ratural", or items 23a or 28a-1 sho ordertt them 27 is anaked other than "ratural", or other traumatic even, the Medical Examiner must be notified at injury or other traumatic even, the Medical Examiner must be notified at Director LAUREL 1 Yes 2 No MONTGOMER 10f. Zip Code 10g. Citizen of What Country? Funeral STREET 20707 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1

✓ Yes 2

No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced BLACK Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) UCK DRIVER TRANSPORTATION 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည GERAND ASCAL SEPHINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR. MonTRUSE BEVERLY SISTER HENNING Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Oa. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 M Removal from State 4-28-2012 BRONX, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNCEAR SENICES 101553 ROAD : BALTO, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Brainstem Immediate Cause (Final Physician/ intarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Peri operative hour potension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Emer enc ao Due to (or a a consequence of): 12 hours The law requires that the death certificate be executed aprita burial-tran attending physician I for use as the buria Physician/Medical adrtic dissection Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) Year signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hypertension Z No 3 Probably 4 Unknown Records, 1 Yes Completed peen Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a. Was an autopsy performe this certificate has page 2 Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending work?
1 Yes 2 No Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined ca 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29b. Signat re and litle of certifier 29c. License number 29d Date signed (Month, Day, Year) DONALD HARRIS, MD 1285958967 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRIS, MD Baltimore S. Greene St. 22 UMMC 31. Date filed (Month, Day, Year, State APR 2 6 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ **Virginia** Mary Prodey Medical Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 😾 F Months Min. Country) 92 Director 218-10-6133 -19-1920 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director items 23a or 28a-f s her must be notified 1 Yes 2 X No Salisbury Maryland Wicamico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21801 USA 26972 Hamden Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, and Mental Hygiene. is marked other than "natural", or iter aumatic event, the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) St. Joseph Hospital Nurses Aid 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Agnes Duffy Alfred Rossman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Salisbury, Maryland 26972 Mr. Charles Prodey - Son 26972 Hamden Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial 04-28-2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility e of Funeral Service Lice 21. Signat 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CEREBROVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death
9 Unknown Month Day Year the. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy performed 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After
mpleted filled in by the funer Natural injury 5 Pending Investigation Accident 6 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the R

completed only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bay Medical Examiner Town, or Location of Death 4c. County of Death MODICA moRe Birthplace (State or Foreign Country) . Date of Birth (Month, Day, Year) **Funeral** Months Director 5,23. assachuesette ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at City, Town or Location 10b. County Director Baltimore MD Yes 2 🗌 No 10e. Street and Number 10g. Citizen of What Country? by Funeral 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 💢 No and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Mail Ha Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, ည pe injury or other traumatic Informant's Name/Relationship (Type Health a permit. Page 1 and Department of Healt, Important: If item 27 any injury or 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License AVERUE Enterthe disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between myo Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform Yes 2 No To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Name and address of person who completed cause of death (Item 23a) Type, Plint) 10 NORTH GREENES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 26 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1050 AM 055 201Z Medical or Location of Death **Examiner** 4c. County of Death Baltimore Spring 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) Funeral Birthplace (State or Foreign Country) **Director** 1 🗆 M 2 💢 F 71 7.2,1940 28a-f show 10c. City, Town or Location must be notified at Director 1

Yes 2 □ No Balt: MOVE 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a Spring 2123 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, : If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BKCK 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Flementary/Secondary (0-12) College (1-4 or 5+) 10 OME Makes win Be 17. Father's Name (First, Middle, Last ဂ Department of Health and M Important: If item 27 is man any injury or other traumat once. od of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig of Funeral Service License Balto . MO 21216 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentiary flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physician and s the burial-transit V 22 ON Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of completed cause of death Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 22 a APRIL 2012 GERTRUD RANDOLPH 5:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER HOWARD COUNTY COLUMBIA HOWARD 5. Social Security Numbe Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) **Director** 112-32-6322 1 □ M 2 🗓 F 92 01/25/1920 AUSTRIA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location te e 10d. Inside City Limits Director notified HOWARD 1 Yes 2 X No MD ELKRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be r Funeral 6391 ROWANBERRY DRIVE 21075 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) SOCIAL WORKER HOME HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental P 1 and 2 should be fill of Health and Mental item 27 is marked 2 LEO GRUNSPAN KATRINA UNKNOWN other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORA GOLDSTEIN/DAUGHTER 7504 KNOLL ACRES ROAD, HANOVER, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CARROLL CREMATION INC:04/25/2012 HAMPSTEAD, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. chal 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ EMENTIA disease or condition 4EHRS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 9 Unknown Unknown Hospital or Attending Physician: The law requires that the ed by the signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy page perform death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 📈 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b, Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending n 24 hours after death.

e Funeral Director: At olderely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation
6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) APRIL 23, 2012

Registrar

State

31. Date filed (Month, Day, Year)

APR 2 6 2012

OBERMANIMD

32. Registrar's Signature

6336 CEDAR LANE COLUMBIA, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mar Registrar	yland / Depa <i>Cer</i>	artment of H tificate of D	lealth and N Death		giene Reg. No. 2013	2 3 3		
	Physicia	in/	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death		
	Medic	al	Dana Janime Robinson 4a. Facility Name (if not institution, give street and number)		4h City Town or	Location of Death	04	22 2012 4c. County of Dea	7:00 AM		
_)	Examir	er	Holy Cross Hospital		Silver			Montgome			
	Funeral			n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9. Bi	rthplace (State or Foreign		
i.	Director		577-11-3772 Usual Residence of Decedent	1 Yrs.	Wichtins Days	Hours Willi.	11/04		GA		
	at at	5		Oc. City, Town or Loc	cation		11/04/	, 1970	10d. Inside City Limits		
	Maryla 8a-f s	Director	DC I	Washington	n				1 X Yes 2 □ No		
	a or 2		10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?		
	th with ms 23 must	Funeral	2024 4th Street NE	· · · · · · · · ·	20002			USA			
(0	er dea or ite	by Ft	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ X No		Vas Decedent of His Yes, specify Cubar		Rican, etc.)	14. Race - Am Black, Whi			
800	ırs aftı ural", I Exar	edk	3 Widowed 4 X Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify: B1	.ack		
5	72 hou "natu edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done de	ution uring most of work	ing	16b. Kind of Business	s/Industry		
72	ithin 7 ene. r than	Sol	Elementary/Secondary (0-12) College (1-4 or 5+)		ONOT use retired) am Analys	t		Environment Protection			
b	illed w il Hygi I othe vent, i	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,		regency		
ylar	Id be Menta arked	2	Robert Leslie Giddens, Jr.			Dorothy	Daniel				
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	11.				r, City or Town, State, Z	ip Code)		
ē,	and and tealt tem 2		Dorothy Brown/Mother 20a. Method of Disposition	2024 20b. Place of Dispos	4th St.		engton,	20c. Location - City o	r Town State		
Baltimore,			1 Keurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, crem	natory or other place			Brentwood,			
alti	permit. Page Department of Important: If any injury or once.		21. Signa are of Firm ral S. puice Licensee					March Funer			
	20 5 6 6		Jamy C. William		_	·		on, DC 2001	1		
			23a Fart 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	edeath. Do not ente	r the mode of dying	, such as cardiac d	r respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician Medical		disease or condition resulting in death) Metastati Due to (or as a co	Lc Breast	Cancer				Chiser and Death		
	Examiner	,		nioquonioo oi).							
	p #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of):							
	ecuter and Il-trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a corresulting in death) Last Due to (or as a corresulting in death) Last								
09	death certificate be executed to attending physician and ed for use as the burial-transit	dical	d								
	tificate ng phy as th	Med	IF FEMALE:						= =====================================		
Box 687	th cer ttendii	ian/	23b. Was decedent pregnant 23c. If yes, outcome of print the past 12 months?	Fetal death 3		/		23d. Date of de Month	elivery Day Year		
	requires that the death certificat been signed by the attending ph should be detached for use as the	Physician/Meo	1 Yes 2 ANO 4 Pregnant at tin	ne of death 5 □	Other (specify)			Wolfill	Day real		
P.O.	law requires that the nas been signed by the e 2 should be detach	by Pr	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
ds,	quires en sig ould b		Acute Renal Failure				1 🗆 1	∕es 2 🛣 No 3 🗆 F	Probably 4 🗌 Unknown		
CO	law re nas be e 2 sh	Completed	Gleutal Abscess				24a. Was a autop	sy prior to	utopsy findings available completion of cause of		
Re	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical				1 Yes	rmed? death? 2 🕱 No 1 ☐ Ye	s 2 🖈 No		
/ita	s certil	To Be	examiner?	2 ER/Outpatient	Othor	ce of Death (Check		ence 6 Other (Spec	- // \		
ot	ding Physician: h. After this certific funeral director,		27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury	at :		ence 6 🗀 Other (Spec ow injury occurred	orry)		
on	leath. or: Af the fu	ifica	1 X Natural 5 Pending (Month, Day, Ye 2 Accident Investigation 3 Suicide 6 Could not be	,ar, Injury	M 1 □ \	res 2□No					
Division of Vital Records,	pital or Attendours after deatleral Director:	Certificate:	4 ☐ Homicide determined 28e. Place of Injury - building, etc. (S		et, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ural Route Number,		
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific etely filled in by the funeral director,	ical	29a. Certifier 1X Certifying Physician: To the best of my	knowledge, death o	ccurred at the time,	date and place, ar	nd due to the ca	use(s) and manner as s	tated.		
	To the Hosp within 24 ho To the Fune completely f	Medical	only one) 3 L Certifying Nurse Practitioner: To the be	r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mar							
	Noriti Con		29b. Signature and title of confifer		29c. License		:	29d. Date signed (Mont			
	•		30. Name and address of person who completed cause of death	(Item 23a) (Time D		61887		04/22/201	2		
			Dr. Ira Y. Rabin 1500 Fore		· ·	r Spring.	MD 209	10			
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	/						
	Registra	ir	APR 2 6 2012 Comma B.	garre							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 23aPtI, II per dr. 2926.04/26/2012dhb

Registrar Registrar Registrar Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day2012 Year Physician/ Abril 16, DOROTHY LOUISE BARCLAY SCOTT Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** KESWICK MULTICARE HEALTH CENTER Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 28 Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 1<u>914</u> Days Min. 1 □ M 2 😾 F Hours 97 Maryland 218-46-2633 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 ☐ Yes 2X No Maryland | Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō is marked other than "natural", or items 23a o aumatic event, the Medical Examiner must be USA 21286 Funeral 624 Sussex Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No þ 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Barclay Frederick Henry Briedner Bynum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 127 Beech Bark Lane, Towson, Maryland 21286 Richard W. Scott 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Green Mount Crematory 4/18/ 2012 21. Signatur / Funer Servi (100)

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Coronary Artery Disease Years Approximate Interval Between Coronary Artery Disease Years Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secuentially list aunditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death ☐ Yes 2 ☐ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure to thrive 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 s autopsy death? performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be funeral director, 26. Place of Death (Check only one) Other: 유 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andres Salazar, MD, 4204 Old Milford Mill Road, Pikesville, Maryland 21208 31. Date filed (Month, Day, Year) State Registrar

3

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G927,5/8/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SEWELL HOWARD 07/7A M 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 31 Good Samaritan NH Hospita ltimore 8. Date of Birth 12/30/1921 9. Birthplace (State or Foreign (Month, Day, Year) If Under 24 Hrs. Hours Min. Social Security Number Age (In yrs. last birthday) Funeral Days Months Director 218-05-1933 1 💢 M 2 🗆 F Yrs. 90 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore MID 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's Road 1803 Hillenwood Baltimore, 1 Funeral 23a 21239 USA 21239 or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates "natural" 3 Divorced Completed Black other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) CKLIPT anton Warehouse perator 10 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Brown Sewell Georgie Haw ard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is Mrs. Thelma Sewell Hillenwood Read Baltimore, MD CS0005e Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Forest Cem. MD 2117 7/25 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) Ja MISON Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, PA Joseph 2222 W. atell Lours IMO 21216 Avenue Ballimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ send disease or condition resulting in death) unkn Brust Medical Due to (or as a consequence of) Examiner Sequentially list conditions, In any, soluting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 2 No been signed by the 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform 2 No 1 Yes 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🗌 No Other: 은 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 28d. Describe how injury occurred 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 2<mark>9c. License numbe</mark>r 29d. Date signed (Month, Dav. Year) 0018230 APRIL 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THIL SHASHUDHAR Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ 100 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) or Location of Death 4b Examiner Hone 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** Months 1 M 2 L Hours 9 Director 4205 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number items 23a Funeral 2 .O Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. ,0 þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes If Yes Give "natural". 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) conday (0-12) ateria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) M.b 20c. Location - City or Town, State 20a. Methed of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) neval Home, Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death signed by the at d be detached for g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed peen : /24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an in the reserved within 24 hours after death.

To the Funeral Director. After this certificate has I for the Funeral Director, After this page 2 s performe 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on€ 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2 3 Day Mildred Claire Sullivan Dru 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HarmoniCare Assisted Living Anne Arundel Severn If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min **Director** 1 🗆 M 2🕶 F 019-03-7201 90 March 8 1922 MASS Yrs Usual Residence of Deceden 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the <u>Medical Examiner must be notified</u> at 10a. State 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21093 USA 224 Burning Tree Road permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: white 3√ Widowed 4 □ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bertha Racoswki Raymond Romec Turconi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Sullivan/daughter 1728 Tacoma Rd., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/25/12 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Dularey Valley Memorial Gardens Timonium, MD 21. Signature of ral Service Cer Michael 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timorium, MD 21093 Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a construence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 anding p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the at d be detached for 9 Unknown g Unknow Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Owner (Specify) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury s after death. 1 Yes 2 No filled in by the Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

60

State Registrar Date filed (Month, Day, Year)

26

millepville

21100

descripted cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Somchanh Sipa	yboı	un State (of Maryland / i	Depa		of Hea	Ith and			-egibi	e. 20	112	1311
Physici Medical Exam	an/	Registrar 1. Decedent's Name (First, Middle,Last) Somchanh Noi Si	payboun	007	incate c	n Dea			2. Date of I Month April 23				of Death
0		4a. Facility Name (if not institution, give Johns Hopkins Hospital					Town, or more	Location of D			lc. County of		
Funeral Director		5. Social Security Number 6. Sex 1 1		In yrs. Ia	ast birthday) Yr	Mont	der 1 Year hs Days		Min.	Birth(MM	ŢF	9. Birthplace (Foreign Country)	
ath with the Maryland tems 23a or 28a-f show any st be notified at once.	Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County N/A 10e. Street and Number 4425 Powell Ave. 11. Mantal Status 1 X Never Married 2 Married	12. Was Decedent Ev Armed Forces?	Ba er in U.		10f. Zi			Y (Specify Yes or erto Rican, etc.)	U.	tizen of What	1 X	side City Limits Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	mpleted by	3 Widowed 4 Divorced 15. Decedent's Education (Specify only Elementary/Secondary (0-12)	or Dates:		16a. Decede	nt's Usua most of wo	orking life.	ion (Give kind DO NOT use	d of work done e retired)		Specify: F Kind of Busir		
1 21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than it event, the Medica	Be	17. Father's Name (First, Middle, Last) $Singkham \qquad I$ 19a. Informant's Name/Relationship (Tyr	nthavong De, Print)				s (Street	Bouaph and Number	or Rural Route	ybou	IN City or Town,		le)
nore, MD ages 1 and 2 sho rt of Health and r: If item 27 is	-	Somchit Sipayboun 20a. Method of Disposition 1 Burial 2 **Cremation 3 **		c	lace of Dispo rematory or o	sition (Na ther place	me of cem	netery,	ve Balt Date /30/2012	20c.	Location - Ci	ity or Town, St	
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify: 21. Specify: Oneral Service License	Mus	~	- 1	Name and	Address	of Facility Road	Ruck Tow Towson,	vson Mary	Funera /land 2	1 Home 21204	
Physician Medical Examiner	9 23		ations that caused the n line. lultiple Injuries ue to (or as a conseque			the mode	of dying, s	such as cardi	ac or respiratory	arrest, sh	ock, or heart		ximate Interval een Onset and Death
e executed sian and rial - transit	I Examiner	cause. Enter Underlying Cause	ue to (or as a conseque			-							
	Medica	UNPENDED	AMENDED 23c. If yes, outcome of	of progn	anov					Laa	d Date of de		
Box 68760, te death certificate be the attending physicited for use as the burited for use	hysician/I	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown	1 Live birth 4 Pregnant at time 9 Unknown	e of dea	2	etal death ther (Spe	cify)	Ectopic pre			d. Date of de Month	Day	Year
Division of Vital Records, P.O. B ral or Attending Physician: The law requires that the d rs after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	2	Part II. Other significant conditions c	ontributing to death bu	it not res	sulting in the	underlying	g cause giv	ven in Part I.	11	res 2 €	No 3	Probably 4 [re autopsy find re to completion	Unknown lings available
Vital Records ysician: The law requi his certificate has been director, page 2 should	Be Completed	25. Was case referred to medical examiner?	spital:					of Death (Che	per 1 ✓ Yes	formed?	deat		2 No
	ို	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Apr 23, 2012		ER/Outpatient 28b. Time of 1447 hrs		28c. Injury	Other ₄ Nu v at Work? es 2 ✓ No	28d. Describ Subject as	e how inju	ury occurred	Other:	
Division of Varieties to the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury (Specify) Single	Fami	ly Home				or Town 5406 Hillbur	, State) n Avenu	ue, Baltimor		Number, City
To the H within 24 To the F complete	Medical	one) 2 Medicai Examiner: 0	: To the best of my kn in the basis of examina and manner stated.			tion, in my	opinion,	death occurre		te and pla	ace, and due	to the cause(s	
		29b. Signature and title of certifier	r W	/		290	O.C.M				Date signed il 24, 2012	(Month, Day, Y	(ear)
0			ant Medical Exam	niner	900 W. E	3altim or	e Stree	t, Baltimo	re, MD 21223	3			
St Regist	ate rar	31. Date filed (APR 2 6 2012	37. Registrar's S	ignatur	ban	رد							

OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 22 Physician/ 3:44 PM S **SUGAR** 2012 HARRIETT HDV. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** al of Baltimoro Hospit Baltimore N/A If Under 1 Year If Under 24 Hrs. Birthpia Country) MD 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 □ M 2 🏻 F Days 09/08/1921 Hours Min. 90 Yrs. Director 217-14-2826 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 72 hours after death with the Maryland Director be notified 1 Yes 2 X No or 28a-f BALTIMORE PIKESVILLE MD Harrist 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21208 USA 33 STONEHENGE CIRCLE, #1 items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Nidowed 4 Divorced WHITE Year or Dates is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry SN (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mental Hygiene. HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ BEULAH SOLOMON SENKER Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and 27 10919 SW 135TH COURT CIRCLE, MIAMI, FL 33186 Page 1 and 2 BETSY TAYLOR / DAUGHTER permit. Page 1 and 2 Department of Healt Important: If item 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition LIBERTY PARK SHAAREI ZION 1 X Burial 2 Cremation 3 Removal from State 04/25/2012 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Mass 6 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 11 days neumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ★ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After injury 1. Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ★ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sma. Hospital of 1a++hew MD Sm:th D 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 Geraldine 18 C. Smith 2012 18:09 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) **Director** 239-66-6414 1 □ M 2 🗶 F 71 12/26/1940 NC 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1XXYes 2 □ No DC Washington 6 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 6313 2nd St. NW 20011 USA ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. P. 1 Never Married 2 XMarried Completed by Yes Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 Divorced Specify: Black Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Elementary/Secondary (0-12) College (1-4 or 5+) Human Resources Clerk 12 Welfare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Freemon Chance Arimetro Raynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Jackson/sister-in-law 8410 Clay Dr. Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemet. 04/28/2012 Annandale, VA 21. Signature of Funeral Service Licen 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 9 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year signed by the at d be detached for Yes 2 X No 1 Yes 2 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 40 completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Mann of Death e Hospital or Attending P 124 hours after death. e Funeral Director: After th 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier MD 0060100 04-18-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 BLUD Sa 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Mental Hygiene Registrar

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death

SKAWM Physician/ Month Medical 4a. Facility Name (if not institution, give street and numb) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAUIMORE 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** If Under 1 8. Date of Birth Birthplace (State or Foreign Country) Min (Month, Day, Year) **Director** 1 🗆 M 2 💢 F 52 Yrs. 8-10-1959 MD show 10c. City, Town or Location at 10d. Inside City Limits Completed by Funeral Director be notified BAUTIMORE 28a-f MD 1 Yes 2 No 0e. Street and Number 23a or 10g. Citizen of What Country? 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: Specify. 3 Widowed 4 Divorced BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNIVERSITY OF MD Elementary/Secondary (0-12) College (1-4 or 5+) CLERK Be 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KEBUSTERS DINCLAIR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEPHEN GLENHAVEN ROAD. BALTO, MO. 21239 HAEL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) GREENG FUNERALSONS 21. Signature of Funeral Service Licensee 1401553 BAUTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day Year 1 Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably Anknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 ていてら ☐ Yes 2 🗌 No e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Z) No Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury 1 Yes 2 No Investigation old not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Produttioner: To the basis of my encurred at the time, date and place, and due to the cause(s) and manner as elected. within 2 nly and at the time, date and place, and due to the 29b. Signature 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uhr. OCMID MD filed (Month, Day, Year, Registrar's Signature State APR 26 Registrar

8:36

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 20 12 hosp.,g926.04/26/2012dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 23 09 PM Geraldine M Thompson APRIL 2012 22 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Months Hours 1 □ M 2 ⋤ F 217-26-1041 March 15, 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 Yes 2 □ No Maryland N:A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 3704 Mary Avenue 21206 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Never Married 2 ☐ Married Yes 2x□ No If Yes, Give 1 ☐ Yes 2 🙀 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Administrative Assistant Hote1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dennis O'Leary Adelaide Egner ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine Stack: Daughter 5705 Walther Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4/27/12 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

items

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"natural",

Examiner

Medical

d other than "

27 is marked or traumatic ever

Department of Health a Important: If item 27 Is any injury or other trau

Director

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

þ

certificate

this

24 hours

within 2 To the f

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Jecongensaled NIG Sequentially list conditions, any, eaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Directo for 8s it nonsequence off: U attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident eral Director A 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

APR 2 6 2012

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) APRIL 22, 2012

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Month

1 Tyes

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

Meraf Wolle, M.D. John Hopkins Bayview,

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylar	nd / Depa	artment of H	ealth and I	Mental Hy	giene	
		_	State Registrar		Cer	tificate of D	eath		Reg. No. 20	112 3 23
ľ	Physicia Medic		1. Decedent's Name (First, Middle, Last) Charles	Louis		Vaeth		2. Date of De Month April	21 20	3. Time of Death Year 2:55 P M
N. May	Examir		4a. Facility Name (if not institution, give st	reet and number)		4b. City, Town, or			4c. County o	
-	·		FutureCare Canton 5. Social Security Number 6. Sex			Balti If Under 1 Year	more Cit			/A
	Funeral Director		220 02 250/	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Aug. 2	y, Year)	9. Birthplace (State or Foreign Country) Maryland
	and show	٥	10a. State 10b. County	10c. Cit	y, Town or Lo	cation		1		10d. Inside City Limits
	Maryls 28a-f	irect		more City			Baltimo	re City		1 X Yes 2 ☐ No
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 1310 Bonsal Stre	et		10f. Zip Code	21224		10g. Citizen of Wh	hat Country?
9	filed within 72 hours after death with the Maryland ital Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	11. Marital Status 1 1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🛣 No		Was Decedent of His f Yes, specify Cubar		ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
-003	hours af natural" ical Exa		3		, .	Yes 2 14No			Specify:	White
21215-0036	within 72 l giene. ner than "r t, the Med	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 Years	College (1-4 or 5+)	(Give I life, D	kind of work done du O NOT use retired) e Leader	uring most of work	ing		1 Bohemian Co.
land 2	should be filed wan and Mental Hyg 7 is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last) Charles J. Vaeth				18. Mother's Nam Emma W		Maiden Surname)	<u> </u>
Maryland			19a. Informant's Name/Relationship (Type Francis J. Vaeth		19b. Mailin 808	g Address (Street ar Falconer	nd Number or Burn Road Jç	al Route Numbe Oppa, Ma	r, City or Town, Sta	nte, Zip Code) 21085
nore,	ge 1 and 2 nt of Healt t: If item 2		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emoval from State	emetery, crem	sition (Name of natory or other place)	Date		City or Town, State
Baltimore,	permit. Page 1 Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee			Faith Ce Name and Address uda-Ruck	and the second second second	5/2012 Home of		ore, Maryland
	ā □ ≟ ē ē		23a. Part 1. Enter the disease, o complice shock, or heat vallure. List only one	cations that caused the deat	100	<u>7922 Wise</u>	Ave. Du	ndalk, l	Maryland	21222 Approximate
	Phylidian Medical		snock, or neat(valure, proving one Immediate Cause (Final disease or condition resulting in death)	Haw 12	eme	nfia				Interval Between Onset and Death
-	Examiner	J.	Sequentially list conditions h	Due to (or as a consequ						
	uted od ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):					, i
0	certificate be executed inding physician and use as the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequ	uence of):					
8760	ificate ng phy as the		IF FEMALE:							
Box 687	death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date Month	*
, P.O.	The law requires that the death ate has been signed by the atterpage 2 should be detached for	by	Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?
ords		Completed						24a. Was a	an 24b. We	Probably 4 Ubnknown ere autopsy findings available
Rec	ician: The law certificate has rector, page 2		25. Was case referred to medical					1 Yes	med? 7 dea	or to completion of cause of ath? Yes 2 40
/ita	sicial s certif	To Be	everniner?	spital:	FD/O to the	Othor	ce of Death (Check			
n of ∖	Attending Physician: ar death. by the funeral director,		27. Manner of Peath 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury : work?		-	ence 6 Other (
Division of Vital Records,	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director,	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in	Medical	(Check 2 L Medical Examine	I ian: To the best of my knowl r: On the basis of examination Practitioner: To the best of m	and/or investi	igation, in my opinion	. death occurred at	the time, date ar	nd place, and due to	the cause(s) and manner stated
	To the within 2 To the сопре	<	29b. Signature and title of certifier		0.	29c. License			29d. Date signed (A	
À			30. Name and address of person who con	y - LUWE U npleted cause of death (Item	23a) (Type, Pi	rint)	D	01/2	7100	2/12
ク	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signat	on Rd	81e C	0411	ma	ullen	D-21254
	Registra	ır .	APR 2 6 2012	Denver B.	gan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town or Location of Death 4c. County of Death th 6. Sex Date of Birth (Month, Day, Year) If Under 7. Age (In yrs. last birthday **Funeral** 9. Birthplace (State or Foreign Months Min. 218-60-2 **Director** 1 ☑ M 2 ☐ F 6 Usual Residence of Decedent 10a State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No timore ö 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be by Funeral 05 items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ed other than "natural", or iter event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore 0+ Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygier 27 is marked other traumatic event, the ore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name elationship (Type, Print) Daug ter. 19b. Mailing Address (Street and Number or Rural ute Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur ral Ser neval Home, MD 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physici_n disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ate has been signed by the atter page 2 should be detached for in the past 12 months? Month Day Pregnant at time of death Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed 2 🗀 No Yes 2 No 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2. No 1 Tyes ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending after death. Accident
Suicide 2 | No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 25-D

DHMH 17 Rev 06-2011

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6

APR

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32. Registrar's Signature

Page Not Found

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>12</u> April Physician/ 19 5:40 AMM Thelma E. Wingo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours Director 217-07-8407 1 □ M 2 🛛 F 93 June 20, Usual Residence of Decedent Maryland ms 23a or 28a-f show must be notified at show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 21613 518 Glenburn Avenue Cambridge, MD USA items 2 death 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Alexander Adams Rose Bronakowska traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Wingo/son 3329 Tidewater Court Olney, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or conce. cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signa ... of Funeral Service 22 Name and Address of Facility.
State Anatomy Board 655 W. Baltimore Street frector Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) sersis Medical Due to (or as a consequence of): **Examiner** multilobar pneumonia Sequentially list conditions and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed ng physician ar as the burial-t Division of Vital Records, P.O. Box 68760 asn ed by the a detached t

ours after death.

eral Director: After this
filled in by the funeral d

29a. Certifier

31. Date filed (Mg

29b. Signature and title of certifie

APR 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji Holy Cross Hospital

Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):						
	resulting in death) Last	Due to (or as a consequence of): d						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of deli Month	very Day Year				
Completed by Pi	Part II. Other significant conditions co dehydration abnormal card	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death, 1 Yes 2 No 3 Probably 4 Unkn 24a. Was an autopsy prior to completion of cause					
Be Co	25. Was case referred to medical	26. Place of Death (Check o		2 No				
To B	T es 2 La No	Hospital:	ne 5 🗆 Residence 6 🗀 Other (Speci	fy)				
Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred					
Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Run City or Town, State)	al Route Number,				

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0064100

Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

April 20, 2012

29c. License number

Registrar DHMH 17 Rev 06-2011

State

within 24 hours a

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Month April 5:02 a.m. Leon William Berube 11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 449-32-8941 1 **X** M 2 □ F 86 02/18/1926 Usual Residence of Decede Texas show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sh notified a St. Mary's Maryland Mechanicsville 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 38005 Lockes Crossing Road 20659 United States items ? within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates. ò Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 - Widowed 4 - Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien
is marked other than a raumatic event, the Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Carl Joseph Berube Marie Vavian and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health t: If item 27 vor other to Mary Virginia Berube / Wife 38005 Lockes Crossing Rd., Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 04/15/2012 Charlotte Hall, Signature of Euperal Service Lice 22. Name and Address of Facility Brinsfield Funeral Home Edward N. Brinsfield, 22955 Hollywood Road, Leonardtown, MD 20650 Jr. MO0052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final hset and Death Multime Physician. disease or condition D e to (or as consequence of) Medical resulting in death) Examiner ERCal cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Streem and burial-tra o (or as a consequence of) resulting in death) Last the attending physician Physician/Medical 4 bruks EREAL Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No g 🗌 Unknown g Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe after death.

Director: After this certificate I Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) House မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Vatural 5 Pending iniury Accident filled in by the Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse re and title of certifie Signal 41502 2012 0 nd address of person who completed cause of death (Item 23a) (Type, Print) 28130 Three Notch Road, Mechanicsville, MD 20659 John W. Roache. M.D. 31. Date filed (Month, Day, Yea 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Burton 7:53 a M amille 10, April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medstar Montgomery Medical Center 01ney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Funeral Hours (Month, Day, Year) 427-48-3881 **Director** 1 M 2 XF 86 Jan. 15, 1926 MS ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes XX No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13800 Loree Lane 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify Completed 3 Divorced 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Lab Tech Supervisor Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ellis Thomenie Oudy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai 13800 Loree Lane, Rockville, MD 20853 Rogers C. Burlton/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 11 13, 2012 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani Arrhythmin 30 mi Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the aid be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Hypertensian 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform this certificate 1 Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this

Completely filled in by the funeral is 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Sign D0058770 4/10/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arcf Olney, MO 20832 18101 Prine Philip Drive Jerm 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistralMEND# 18+20bperINF,4/18/12;BWW,MccCertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 20 T2 Robert Eugene Bornsheuer 6:00 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring 9435 Curran Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 347-20-9975 Director 1 2 M 2 □ F 84 May 21, 1927 ILUsual Residence of Decedent sho 10b. County or then "natural", or items 23a or 28e-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Silver Spring 1 ☐ Yes 2 🛣 No Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20901 USA 9435 Curran Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify.White If Yes, Give 1948-75 1 ☐ Yes 2 ☒ No Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Systems Supervisor|Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) Mabe I 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic even Mabele Linda Harris Charles Henry Bornsheuer i. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) Step-daughter, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina M. Incognito 9435 Curran Road, Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date UKN 20c. Location - City or Town, State Ariington National Cemetery permit. Page Department of Important: If eny injury or ". გ 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, 4-26-2012 21. Signature of Funeral Service Licensee Francis Address Corillins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) page 2 should be detached 2 No g Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. baugis (23e. Did tobacco use contribute to the cause of death? δ Paroxysmal Ventricular Tachycardia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Aft completely filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) з 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Wilkinson Ninala, MD

2 2012

31. Date filed (Month, Day, Year)

Registrar's Signat

344 University Blvd. W., Silver Spring, MD 20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 2012 2:40 Georgia Ann Boyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 761 South Potomac St. Washington County Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Hours 218-62-7905 59 Director 1 🗆 M 2 💢 F Nov. 2,1952 Maryland ural", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 X Yes 2 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 761 South Potomac St. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🎇 No Specify. White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store 12 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Geraldine Doloris Worthington William Lionel Gelwicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Boyd-husband 761 S. Potomac St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Smithsburg <u>Crematory</u> 4-6-2012 Smithsburg, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Prynician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last ending physician ause as the burial Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter | for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the i 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0066930 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 9 2012 Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #31 per HD, 04/13/12, ca Certificate of Death amend item 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** 11, 2012 April Mary V. Buell /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Somerset 30472 Plantation Drive Princess Anne If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 2 F Sept.25, Director 1920 | Maryland 579-26-6353 91 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Princess Anne Somerset Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or U.S. 30472 Plantation Drive Funeral 21853 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Neyer Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 Registered Nurse Healthcare other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hi ant: If item 27 Is marked oth Be Lyman J. Lattimore Sally Ann Bozman item 27 Is marke other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah B. Kodros Daughter 1628 Highbranch Way, Hillsborough, NC. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages ' Department of h Important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State St. Andrews Epis. Cem 04/14/2012 Princess Anne, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, Md. 21853 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immunished Cause (Final disease or condition)

a. Complete V. V. Lond Hourd Physician resulting in death) /Medical Due to (or as a Insequence of): Examine Valvular Equantian list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical as attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Month Day Year 5 Other (specify) Ö the detach**e**d 9 Unknown þ م 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ 2 No 3 Probably 4 Unknown 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy certificate 2 1 No 1□ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 | Inpatient 2 this 27. Mann of Death funeral 28b. Time of 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After 1 Certification: (Month, Day Year) Injury Division 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🛘 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 0 e of death (Item 23a) (Type, Print) 30. Name 32. Registrar's Signature (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department		Mental Hygier	ne	13132				
		_	Registrar	rtificate of Death		No. 2012					
	Physicia Medio		1. Decedent's Name (First, Middle, Last) Rose Anne Courtney		2. Date of Death Month April 7	Day 2012 Year	3. Time of Death 5:15 P M				
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomer	v				
3 T	Funeral		Bartholomew House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign				
	Director		058-24-0103 1 □ M 2 X F 82 Yrs.	Months Days Hours Min.	(Month, Day, Yea 07/04/19:	ar) Coun					
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	01/04/27		Od. Inside City Limits				
	Maryla 28a-f s atified	recto	MD Montgomery Bethesda				1 Yes 2 No				
	with the 23a or 3	Funeral Director	10e. Street and Number 4850 Park Avenue	10f. Zip Code 20816	10g. U1	. Citizen of What Cour nited Stat	ntry? .es				
(0	or items	by Fun	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,					
0036	urs afte tural",	ted b	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐XNo Specify:		Specify: Wh	ite				
15-	n 72 ho an "nai Medici	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work O NOT use retired)	ing	o. Kind of Business/In	dustry				
212	within giene, per tha t, the I		Leiementary/secondary (U-12) College (1-4 or 5+) Accou	intant		Education					
Baltimore, Maryland 21215-0036	d be filed Aental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last) Anthony Santomauro	18. Mother's Nam Assunt a	e (First, Middle, Maid Lannuzzi	den Surname)					
Man	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ng Address (Street and Number or Rura) Park Avenue Beth			Code)				
ore,	ge 1 and it of Hea if item or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cremetery, cremeters, cremeter	matory or other place)		c. Location - City or To					
Ħ.	nit. Pagartmen artmen ortant: injury		4 Donation 5 Other (Specify) Calvertor 21. Signatural Funeral Sepace Licensee	Nat. Cemet. 4/13 2. Name and Address of Facility Jos	3/2012 C	alverton,					
Ba	Dep Imp any once			5130 Wisconsin Ave							
ľ			23a. Part 1. Enter the disease, or complications that caused the death. Do not entended shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death				
5.	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Lung Cancer Lung cancer Due to (or as a consequence of):				Offset and Death				
	Examiner	<u>_</u>	Sequentially list conditions.								
	d d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events c.								
	ate be executed hysician and the burist transit	al Ex	resulting in death) Last Due to (or as a consequence of):								
760	cate b physic	edical	d								
Records, P.O. Box 687	eath certificat attending ph	Physician/Me	In the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ery Day Year				
Ö.	t the dea by the a stached	hysi	9 ☐ Unknown								
s, P.(iires that 's signed build be det	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		co use contribute to the	ne cause of death?				
cord	law require nas been si e 2 should l	Completed			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of				
Be	ician: The law certificate has rector, page 2		25. Was case referred to medical	OC Place of Death (Class	performed		2 🗆 No				
/ita	ysician: is certifica director,	To Be	examiner? 1	26. Place of Death (Check		e 6 XOther (Specify	Hospice				
n of \	ding Phy th. After this funeral o		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how in		позрісс				
Division of Vital	al or Attendi s after death. I Director: A ed in by the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street City or Town, Str	t and Number or Rural late)	Route Number,				
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours and the death. To the Funeral Director, feet this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial terms.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invest	tigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the car	use(s) and manner stated.				
	To the within 2 to the comple	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D								
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, F	P		4.10.12	-				
			30. Name and address of person who completed cause of death (Item 23a) (Type, F Debrah Miller CRNP 1355 Piccard Dr.		le, MD 208	350					
	Stat Registra		31. Date filed (Month, Day, Year) APR 12 2012 32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 Day 2012 Year Physician/ April Mary M. Chrzanowski рМ 1:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harmony Hall Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min **Director** 1 □ M 2 🔀 F 216-20-6807 87 07/08/1924 MD Usual Residence of Deced 28a-f show 10d. Inside City Limits at 10a. State 10c. City, Town or Location Director the Medical Examiner must be notified 1 ☐ Yes 2X No MD Ellicott City Howard 10e Street and Number 10g. Citizen of What Country? ò 23a Funeral 3411 Coventry Ct. Drive 21042 United States Il Hygiene. other than "natural", or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file I and Mental F ၉ George Sotaski Mary Syminski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is Thomas Chrzanowski - Son 1900 Frederick Road Catonsville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) permit. Page 1 Department of Important: If ii any injury or o 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 04/12/2012 4 Donation 5 Other (Specify) Stanislaus Cem. Baltimore, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee all 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line FAILURE Onset and Death Immediate Cause (Final HEART CONGESTIVE Physician/ EARS-MON, disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 menths?
1 Yes 2 No Pregnant at time of death 5 Other (specify) the hed 1 | Yes 2 | 9 | Unknowr 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed k should be det 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA, ARTERY DISEASE, 2 2 10 of Vital Records. 1 🗌 Yes 3 Probably 4 Unknown Completed PNEUMONIA HYPERTENSION 24b. Were autopsy findings available 24a. Was an autopsy performed 1 Yes 2 page 2 s prior to completion of cause of death?

1 Yes 2 No Director: After this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be A5315TED LIVINGS Other (Specify) FACI examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1. Natural (Month, Day, Year) 5 Pending Division 1 🗌 Yes 2 🗌 No M filled in by the 2 Accident Investigation 6 Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after 24 hours a Medical Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hatema 09,0 09 D0069962 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fatima A. Naqvi, MD 6334 Cedar Lane Columbia, MD 21044 31. Date filed (Mont Registrar's Signature State Barks reun Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 April Physician/ Hsiao-Ho Chang 9. 5:15 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Arcola Health & Rehab. Center Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 217-23-9301 1 □ M 2 1 F Director 92 Yrs. Feb. 1, 1920 China Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Montgomery Silver Spring 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 5 Darcy Green Court 20910 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yu-Cheng Chang Chow-Shi Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12604 Falconbridge Drive, Gaithersburg, MD 20878 Kai-Xuan Chang/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth April 10 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 2012 Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration Pneumonitis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No this certificate has been signed by the a ral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dysphagia with Malnutrition 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No ☐ Yes **Division of Vital** 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🖾 No ဍ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral v. 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XX Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number D45471 April 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Yeheyis Negussie, MD

31. Date filed (Month, Day, Year)

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death □2012 Physician/ April 7. Thomas Crosslev 7:24 Albert рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13908 Sunrise Drive Washington Maugansville If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) (Month, Day, Year) (Acamber 12,1920 New 1 M 2 D F Days Months Hours Director 91 154-14-8289 December Jersev Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Maugansville Washington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 13908 Sunrise Drive 21767 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Armed Forces:

1 XYes 2 No
If Yes, Give 3 Aug
Year or Date 7 Dec þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1942 1945 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 27 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Mfg. Pipe Organs Draftsman Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ပ Thomas Quambry Crossley Garlock **Fmma** Kate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and Department of Health a Important: If item 27 in inv or other tr M. Lucille Crossley Wife 13908 Sunrise Drive, Maugansville, Md. 21767 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory |Hagerstown, Maryland Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Signature of Funeral Service Licensee Md. 21740 23a. Part 1. Enter the disease, or compecations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final aucen -Physician/ disease or condition resulting in death) Medical as a consequence of Due to 60 Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ξ Month Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completed filled in by the funeral director, page 2 autopsy perform certificate ! 1 Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c} \begin{array}{c} \text{Residence} & 6 \sup \text{Other} \) Other (Specify) 2 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner J 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Z** Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one To the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

TN-5+

State Registrar 31 Date filed (Month, Day

MUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



3665.

April 7, 2012

Physician Medical **Examiner** Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

þ

Completed

Be

2

Signature

IF FEMALE

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Medical

event, the

permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event. the

filed within 72 hours after death with the Maryland all Hygiene. dother than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar Physician/Medical the been signed by þ Completed has page 2 certificate funeral director. æ 은 Director: After this Certificate:

25. Was case referred to medica

examiner? 2 M No 27. Mann of Death 1 V atural 5 Pending

3

29b. Signature and title of certifier

Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide determined

Inpatient 2 28a. Date of injury (Month, Day, Year) Investigation Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

ER/Outpatient 3 DOA

work? 1 ☐ Yes 2 ☐ No

28c. Injury at

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 Residence 6 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHUBE DRI SALISBURY MD 21804 FASTERW

State Registrar

Medical

29a. Certifier

only one)

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2012 8:00 PM Delores Parrott Carter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot 9107 High Banks Drive Easton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Year) 926 Months Days Hours Min (Month, Day, Yes 1 🗆 M 2 💢 F Georgia Director 255-42-2308 85 Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director items 23a or 28a-f s ner must be notified 1 🗌 Yes 2 💢 No MD Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21601 United States 9107 High Banks Drive death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Medical Examiner Armed Forces?

1 Yes 2 X No "natural", or g 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic access Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ P.A. Parrott Ruth Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Gray Carter/spouse 9107 High Banks Drive, Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MidShoreCremationCtr. 4/16/2012 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mid ShoreCremation Center CPSP P.O. Box 1464, Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death men TIM Immediate Cause (Final 0 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) death certificate be executed tran and Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the a n signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has k completed filled in by the funeral director, page 2 si 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work Accident
Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 51132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton, Md. 21601 598 Cynwood DR. JORGE ABREGO 31. Date filed (Month, Day, Year) 32. Registrar's Sig State Registrar

DHMH 17 Rev 7/2009

A56

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 22, per fh, g926 4-26-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DONALD GENE DOSS 1:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Med. Center Bel Air Birthplace (State or Foreign Country)

WV If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 235-56-7689 5/2071939 Director 1 XM 2 □ F 72 Usual Residence of Dec 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** notified a MD Harford Whiteford 28a-f 1 Yes 2X No 10g. Citizen of What Country? o 10e. Street and Number 10f. Zip Code must be 23a 1505 Ridge Road 21160 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: SpecifWhite "natural", 3 - Widowed 4 X Divorced Completed : If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. Truck Driver Transportation Be 17. Father's Name (First, Middle, Last)
Marvin Clayton Doss 18. Mother's Name (First, Middle, Maiden Surname) Ruth Vernell Cutlip 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Ridge Road, Whiteford, MD JoAnn Slade/Companion 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/16/12 Bel Air, MD Bel Air M. Gdns. 21. Signature of Sone al Service Lice se 22. Name and Address of Facility Harkins Funeral Home Inc Delta,PA,17314 600 Main Street 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ -417Phangiti e Noccord disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events C and resulting in death) Last Physician/Medical Doss, Donald Gene IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dreutonia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an en bolus autopsy performed? Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident after deatl Director. Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 88 Hospital within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier 1 Certilying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) April11, 2012 pleted cause of death (Item 23a) (Type, Print) 30. Name a 7Lmalab State Registrar

12-02923

Arier: ded #28f, 04/18/12, RML, St. Mary's County
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Edward		Sey S I- For State Registrar	tate of Maryla		irtment of <i>tificate</i> of		and Me	ental Hy	_	eg. No.	201	2	1313
Physicia Medical Exami	an/	1. Decedent's Name (First, Mid- Michael	die,Last) Edward	Daisey	7				2. Date of Dea Month April 14, 2	Day	Year		of Death 8 hrs
		4a. Facility Name (if not instituti St. Mary's Hospital	on, give street and num	nber)	1	tb. City, Tov Leonard	n, or Location	on of Death			ounty of Dear	th	
Funeral Director		5. Social Security Number 219-02-2107	6. Sex 7	7. Age (In yrs. la 43		If Under Months		nder 24Hrs. ours Min.	8. Date of Bir		Fore	irthplace (ign Was ountry)	State or hington, DC
ow any		Usual Residence of Decedent 10a. State 10b. County			Town or Locati				_				side City Limits
vith the Maryland s 23s or 28s-f show s e notified at once.	Director	Maryland St 10e. Street and Number 36668 Owens	. Mary's Drive		Bushwoo	10f. Zip Co	ode 20618		1		n of What Co		
2 hours after death v "natural", or item	Completed by Funeral	15. Decedent's Education (Sp Elementary/Secondary (0-12	Married Armed For 1 Yes vorced If Yes, Give Year or Dates: ecify only highest grade	2 X No	1 1 16a. Deceden during me	Yes 2 X t's Usual Ocost of working	No speci cupation (Ging life, DO No	can, Puerto I sify: ve kind of w	ork done	Sp. 16b. Kind	I. Race - Ame White, etc. Decify: d of Business AVY Eq	White Vindustry	е
215-0036 be filed within 7 ttal Hygiene. riced other than		12 17. Father's Name (First, Middle			Servi	ce Ma	18.Moti		(First, Middle, I	Maiden Su	ırname)	итрш	епс
MD 721 2 sho ld be fi 1 and Mental 27 is marked mati event,	To Be	Raymond M 19a. Informant's Name/Relation Vanessa Daise	ship (Type, Print)	у			Street and N		Hui ural Route Nur ushwood		or Town, Stat		de)
Baltimore, Nemit. Pages I and Department of Health Important: If item.	167	20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other 5	n 3 Removal from	m State Mat	Place of Disposerematory or other tingleymeral Hom	erplace) Gardine e, P.A.	r Cremato	04/	Date 19/2012	Lec	cation - City o	own,	MD
Physician Physician		21. Sig e of Funeral e (2) 22. Sig 22.	Nahalise	used the death.	1 '	41230	LEHMI	CK SL	ner Fun ., Leon	aruc	JWII, FII	200	50 ximate Interval
/Medical Examiner		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line. e a. <mark>Multiple Injul</mark> Due to (or as a c	ries								Betwe	een Onset and Death
ecuted and - transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c Due to (or as a c d.										
), be ex sician urial		UNPENDED AMENDED									Year		
P.O. es that the igned by	Ď	1 Yes 2 No 9 U	g Unknow		esulting in the u	nderlying ca	use given in	Part I.			contribute to		
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	Completed					-			24a. Was autop perfor 1 V Yes	sy m <u>ed</u> ?		completio	dings available n of cause of 2 No
of Vital Recing Physician: The After this certificate timeral director, page	B	25. Was case referred to medic examiner?	11 11	patient 2	ER/Outpatient		Place of Dea Other			Residence	e 6 Othe	er:	
ion of Vertical Control of Contro	ation: To	1 V Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Assident	28a. Date o (Month) Apr 14, 2	f Injury	28b. Time of Ir 1347 hrs	njury 280	Injury at W	No S	28d. Describe Subject mot accident			in moto	r vehicle
Division To the Hospital or Attendiu within 24 hours after death. To the Funeral Director. /	Certification:	2 Accident Investigation 3 Suicide 4 Homicide Investigation 6 Could not be determined Investigation 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town, State) Notley Maddox Road and Hottley Half Road, Chaptico, MD									Number, City tico, MD		
To the Hospital within 24 hours To the Funeral	Medical	(Direct City)	Physician: To the best aminer:On the basis of and manner sta	examination a									s)
• H 3 H 3	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon April 15, 2012										onth, Day,	Year)
Berne		3 Name and address of perso Theodore M. King, Jr	., MD. Assistar	nt Medical E		900 W. B	altimore S	Street, Ba	ıltimore, MI	21223			
S Regis	tate trar	31. Date filed (Month, Day, Year APR 18	2012 Fener	gistrar's Signatu	park	7							
DHMH 17 Rev 1/2	001				ORIGINA	L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Der Sta	Department of He SP22/2012 Inb Certificate of De	alth and M eath	lental Hygid Reg	ene g. No. 20	12 13140
	Physicia	/	1. Decedent's Name (First, Middle, Last)		_	2. Date of Death	• Day V	3. Time of Death
	Medic	al	Mary Dunning Daley			April 4	2012	10:28 AM
	Examin	CI	4a. Facility Name (if not institution, give street and number) Carriage Hill Nursing Home		nesda		Mon t	gomery
	Funeral Director		317 10 0/33		f Under 24 Hrs. Hours Min.	8. Date of Birth Dec. 8 Day 9	26	g. Birthplace (State or Foreign IIIInois
	how at	ے	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	laryfa 3a-f s iffied	ect	Md. Montgomery K	ensington				1x Yes 2 □ No
	or 28	흐	10e. Street and Number	10f. Zip Code		10	g. Citizen of Wh	at Country?
	s 23a	Funeral Director	9714 Summit Avenue	2089	95		USA	
99	ifter death ", or item aminer m		11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give	American Indian, White, etc.				
ö	ours a atural	Completed by	3 ☐ Widowed 4 🔀 Divorced Year or Dates.	1 Li Yes 2 K No 3		1.	Specify:	White
15	72 h	Jdw	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	ng most of worki Societ	ng V	6b. Kind of Busi $f Tour \;\; Gu$:	
212	within giene. er tha			ional Capitol			U.S. Ca	pitol
Baltimore, Maryland 21215-0036	e filed ttal Hyg ed oth event	To Be	17. Father's Name (First, Middle, Last) William Franklin Dunning	18	8. Mother's Name	e (First, Middle, Ma	iden Surname)	
ट्रें	d Mer mark mark							4- 75- 0 a de l
Ma	2 sho Ith an 27 is trau	12	Patricia Daley Hodgson/daughter	Mailing Address (Street and				
re,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of	Disposition (Name of	1	Date 20		ity or Town, State
E			I Dullar 2 La Oremation 5 D Nemova nom State	y, crematory or other place) colitan Crem.	April 20		AL	exandria, Va.
alti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee MO1315	22. Name and Address of				
ш	205 20	- 14	Mili IT DOW	-				on, DC 20007
7	Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Re Due to (or as a consequence or consequence	nal Cancer	such as cardiac c	r respiratory arrest		Approximate Interval Between Onset and Death
09	ate be executed bhysician and the burial transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence or cons					
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of delivery Month Day Year			
P.0.	ires that the signed by do be deta		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given	in Part I.	23e. Did toba	cco use contribu	ute to the cause of death?
ds,	requires been sig should be	ed t				1 ☐ Yes	2 □ No 3	☐ Probably ¾ ☐ Unknown
Recor	The law recate has be based age 2 sho	Completed by				24a, Was an autopsy performe	ed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\subseteq \) No
la	ysician: The la is certificate hadirector, page	Be (25. Was case referred to medical examiner?		of Death (Check	only one)		
Ξ	Physic this co	은	1			me 5 Residen		(Specify)
n o	ding Ph th. After th funeral	ate	1 X Natural 5 ☐ Pending (Month, Day, Year) in	njury work?	s 2 🗆 No	28d. Describe how	injury occurred	
Division of Vital Records,	I or Attendater deat Director:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)			28f. Location (Stre City or Town,		or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	29a. Certifier (Check only one) 3 X Certifying Physician: To the best of my knowledge, do nly one) 3 X Certifying Nurse Practioner: To the best of my knowle	r investigation, in my opinion,	death occurred at	the time, date and	place, and due to	o the cause(s) and manner stated.
	vithir To th	2	29b. Signature and title of certifier	29c. License nu				Month, Day, Year)
	1		Mile Han Dung, Ca	WP R	144786		Apri	1 6, 2012
			30. Name and address of person who completed cause of death (Item 23a) (T		D 1	77	20050	-
	- Ch		Mila Harding, CCNP, 10110 Mol 31. Date filed (Month, Day, Year) 2. Registrar's Signature		, Kockvi	.ile, Md.	20850	
	Sta Registra		31. Date filed (Month, Day, Year) 22. Registrar's Signature APR 12 2012	gares.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death April Physician/ 18 2012 Esta M. Dunlap 2014 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 467 Marley Road E1kton 5. Social Security Number if Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Davs Hours March, 19, Year 1929 Pennsylvania 83 220-22-4856 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 💹 No Maryland Ceci1 E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **Funeral** 21921 United States 467 Marley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Esther Barrett Daniel Blair Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 North Street, Elkton, MD 21921 John C. Dunlap, Sr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Elkton Cemetery 2012 Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals, 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hronic years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury that is it is to a second or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No been signed by the atte Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has death?
1 Yes 2 No Yes 2 X No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 St Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

W

Medical

29a. Certifier

(Check only one) 29b. Signature and title of certifier

53900 ARLO 31. Date filed (Month, Day, Year, State 6 2012 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carhedral Street 138 32. Registra 's Signa

🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

65902

EIKhon

29d. Date signed (Month, Day, Year)

21921

12

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AOT I 3330 PM Betty Lou ELGIN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Meritus Medical Center Washington Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months 214-32-2755 **Director** 1 □ M 2 F 77 Yrs June 18,1934 Maryland 28a-f shov at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified Maryland 1 🗌 Yes 2 🔀 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ıral", or items 23a or Examiner must be r Funeral U.S.A. 67 Brightwood Drive 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", Medical Exan If Yes, Give Year or Dates white 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) the Travel Agent Trave1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental P is marked o Department of Health and Menta Important: If item 27 is marked any injury or other transce. ၉ Kenneth Sinn Henrietta Betts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phil Elgin - Husband 67 Brightwood Drive, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State Hagerstown Crematory April 2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptomician/ Tag disease or condition Medical resulting in death) r as a consequence of) 1 Week **Examiner** Sequentially list conditions Examine Due to for as a consequence of if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 2 No 3 Probably 4 onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy 3) 1 Yes 2 No certificate nenu Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referre to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 21 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of cert 29c. License number 29d. Date signed (Month. Day, Year)

JW-5

State 31. Date filed (Month Day, Year Registrar

350 MICL S 2 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAGERSTOWN MD 21746

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death :29 AM Physician/ GREENWALD Emily Apn Medical 4a. Facility Name (if not institution, give street and number) . City, Town, or Location of Death County of Death
Washington Examiner Hagerstown Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, 215-40-2706 Maryland Director 1939 1 □ M 2 F 72 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Hagerstown Yes 2 No Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must to 935 The Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc ☐ Yes 2 🛣 No Yes, Give 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) her own home homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Segel ပ Peter Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Maryland 21742 19a. Informant's Name/Relationship (Type, Print) Melvin Greenwald - husband 935 The Terrace, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory 20c. Location - City or Town, State Department of h Important: If ite 1 Burial 2 X Cremation 3 Removal from State injury or April₂₀₁₂ Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat e o Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ soutor d Andsdisease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) signed by the aid be detached to 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Tes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cectifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) D0038764 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 STE 127 Contra Hogenbun 41742 Russe mo 11115 31. Date filed (Month egistrar's Signature State Registrar

	r	30. Name and address of person who c	ompleted cause of	death (Item 2	23a) (Type Pr	int)		_						
		b digitalis and united to the state of the s	M				icense n	055	75	-1		ate signed		
	Medical	(Check 2 Medical Examionly one) 3 Certifying Nurs 29b. Signature and title of certifying Nurs	ner: On the basis of $\mathfrak c$	examination	and/or investig	gation, in my death occurr	opinion, red at the	, death occi time, date	urred at the	ne time, date a	and place the cause	e, and due e(s) and m	to the ca	use(s) and manner s stated.
		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of In	tc. (Specify)				date and n		City or Tov	vn, State	e)		Route Number,
	Certificate:	27. Manner of Death 1			28b. Time of injury	28c	. Injury a work? 1 🔲 Ye	at es 2□N		3d. Describe I	now inju	ry occurre	d	Hous
- 1	္	TE Yes 2 Lavo			R/Outpatient		Other			ne 5 ☐ Resi	dence	6 Othe	r (Specify	Hospin
		25. Was case referred to medical					26. Plac	e of Death	(Check	auto perfo		p	rior to co leath?	mpletion of cause
	Completed b									1 🗆				bably 4 ☐ Unknopsy findings availal
i	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did t	obacco	use contr	ibute to t	he cause of death?	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							15			23d. Dat	e of deliv	ery Day Year
- 1	ical Examiner	if any, leading to immediate Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):												
on cal ner	Je.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	MO s a con fer ue	ence of):	rcer								Onset and Death
		Danielle Ward 23a. Part 1. Enter the disease, or compensors, or heart failure. List only o	M01403 Discations that cause ne cause on each line	ed the death						d, Leo: respiratory a		ltown	, MD	20650 Approximate Interval Between
once.		21. Signature of Funeral Service Lice is	aniella	One	2 22.	Name and	Address	of Facility	Bri	nsfiel	d Fu	nera	1 Ho	Maryland me, P.A.
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		e ce	ace of Dispos	atory or oth	er place,			ate				own, State
	- 1	Janet Hayden/Wife		17.						Route Number				
	우	Joseph A. Hayden, 19a. Informant's Name/Relationship (7)			10h Maiti-	- 4-1	_			ta Abe		T 0	=	0.11
	Be	1.2 17. Father's Name (First, Middle, Last)			Brick	layer		18. Mother	r's Name	(First, Middle		sonry o Surname		
Out of the second of the secon	Completed	(Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give k life. DC	ind of work NOT use r	done du	inng most	of workin	g		Kind of Bu		idustry
		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	-	1 16a. Deced	Yes 2					101	Specify:	Wh	ite
	by Fu	11. Marital Status1 ☐ Never Married 2 X Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 🖸	?					in? (Spec Puerto F	ify Yes or No- Rican, etc.)			e - Ameri k, White,	can Indian, etc.
	neral	24465 Morgan Road	, Apt. #1			206	36					ted S		í
	Funeral Director	Maryland St. Mary 10e. Street and Number	s	Holly	ywood	10f. Zip (Code			-	10a. C	Citizen of V	What Cou	1 ☐ Yes 2 X
5	ctor	10a. State 10b. County		1	, Town or Loc	ation							- 1	10d. Inside City Lir
tor		215-56-9577 Usual Residence of Decedent	X M 2 □ F	59	Yrs.	Months	Days	Hours	Min.	(Month, Da		- 1	Mary	ntry) 71and
ral		Hospice House of 5. Social Security Number 6. S		ge (In yrs. Ia	st birthday)	If Under	1 Year	If Under 2		8. Date of Bi	rth	t. Ma	9. Birth	place (State or For
min		4a. Facility Name (if not institution, give	street and number)					Location of	f Death		4	c. County	of Death	
edic	n/	Francis William	,	n						2. Date of De Month April	D	2012	Year	3. Time of Dea 4:24 p.
ioia		1. Decedent's Name (First, Middle, Las												

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 19a, per fh, g927 5-3-12 sm.
State of Maryland / Department of Health and Mental Hygiene 2012

			State Registrar		-	Certifica	te of L	Death			Reg. No).	
П	Dhysisis	_,	1. Decedent's Name (First, Middle, L	.ast)						2. Date of Dea Month	ath Da	v Year	3. Time of Death
	Physicia Medic	al .	Senorina Jimen							April	6,	2012	6:15A ^M
	Examin	er	4a. Facility Name (if not institution, ga					r Location o				. County of Death	
Year of			48 Michael Cour 5. Social Security Number 6.		e (In vrs. last birl			ersbui		8. Date of Birth		Montgome 9. Birth	Pry pplace (State or Foreign
	Funeral Director		217-92-1959	1 □ M 2 🕱 F	75	Month Yrs.		Hours	Min.	(Month, Day	, Year)	Cou	ntry)
			Usual Residence of Decedent	A.	13	113.				April 2	28,	1936 Mex	
	rland f show ed at	tor	10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Limits
	Mary 28a-i otifie	irec	Maryland Montgo	nery	Gait	hersbur							1 Yes 2X No
	h the	무	10e. Street and Number				Zip Code				-3	tizen of What Cou	
	th wit ms 23 must	Funeral Director	48 Michael Cour				20877		. 0 /0	* Y N	Un	ited Sta	
	r deal	y Fu	11. Marital Status1 ☐ Never Married 2 X Married	12. Was Decedent E Armed Forces?		13. Was Dec	edent of H secify Cuba	lispanic Orig an, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
36	al", o	d by	3 Widowed 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No	1 X Yes	2 🗌 No	Specify:	Mex	rican		Specify: His	panic
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's	s Education	16a	. Decedent's Us					16b. K	ind of Business/I	ndustry
215	in 72 e. nan "	삞	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5	i+)	(Give kind of v life. DO NOT u	vork done (ise retired)	auring most	or work	ng			
7	with gien er th t, the		3		H	ousekee	per					Hospita	a1
nd	tal Hyded oth	To Be	17. Father's Name (First, Middle, Las	t)						e (First, Middle,		Ĺ	
yla	Men Men narke	۲	Benjamin Quiros							pe Alvai			
Baltimore, Maryland	should be filed wand Mental Hyg rand Mental Hyg ramaric event,		19a. Informant's Name/Relationship Efrain	(Type, Print)								Town, State, Zip	
o)	ge 1 and 2 s it of Health if item 27 i		Efsain Jimenez - 20a. Method of Disposition	- spouse		Michae of Disposition (A		urt, (aryland	
Jor			1 🗌 Burial 2 🔀 Cremation 3	☐ Removal from State	cemete	ery, crematory o	r other plac			Date			
Ħ	it. Partmer rtant rtant njury		4 Donation 5 Other (Spe			Park C			-				Maryland
Bal	permit. Page Department of Important: If any injury or once.	ļ	21. Signature of Funeral Service Lice	ensee MO1	102			ss of Facilit		imple Ti			1 00050
÷	_		23a. Part 1. Enter the disease, or co	omplications that caused	the death. Do							e. Mary	Approximate
	ota statan (shock, or heart failure. List only Immediate Cause (Final	y one cause on each line	on each line.								Interval Between Onset and Death
الخد	Ph _y sician/ Medical	i	disease or condition resulting in death)		atic Ca a consequence								
*	Examiner			Bus 15 (5) us 1	a condoquence	01).						1	
L.		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):							
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687	intifica ling p		IF FEMALE:	23c. If yes, outcome	of preamancy								
X	ath ce attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 4 Pregnant a	2 Fetal deat	h 3 Ectop 5 Other		су			ĺ	23d. Date of deli Month	very Day Year
Box	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial tension	Physician/	1 ☐ Yes 2 🗶 No 9 ☐ Unknown	9 Unknown	t time or death	3 🗆 Other	(apecity) _						
P.O.	hat the ed by detay		Part II. Other significant conditions	s contributing to death b	out not resulting	in the underlyin	ıg cause gi	ven in Part	l.	23e. Did to	obacco i	use contribute to	the cause of death?
S,	ires t sign lid be	d by								1 🗆 🕆	Yes 2	▼ No 3 □ Pro	obably 4 🗆 Unknown
ord	v requ	Completed								24a. Was a			opsy findings available
ec	The law ate has page 2	E O								autop perfo 1 Yes	med?		ompletion of cause of
E	ician: The certificate rector, pag	Be C	25. Was case referred to medical	1			26. P	lace of Dea	th (Chec		2 /2 0 IN	ol III les	2 140
Zit:	ysicia is cer direc	To B	examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatient 3 🗌	DOA Oth	ner: 4 🗆 Nu	ursing Ho	me 5 X Resid	dence 6	6 Other (Specia	fy)
Division of Vital Records,	ng Ph ter th		27. Manner of Death	28a. Date of inju (Month, Da)		Time of injury	28c. Injur	ry at k?		28d. Describe h	ow injur	y occurred	
on	endir sath. or: Af the fu	fica	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat	tion		М		Yes 2	No				Carlo Company
VISI	r Att fer de irecton n by 1	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine			arm, street, fact	ory, office			28f. Location (S City or Tow		nd Number or Run e)	al Route Number,
Ö	ospital of hours at neeral D			8.7									
	五谷 四部	Medical	(Check 2 Medical Exa		xamination and/	or investigation,	in my opini	ion, death o	ccurred a	t the time, date a	nd place	e, and due to the c	ause(s) and manner stated.
	To the within 2 To the Comple	Σ	only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practitioner: To the	e pest of my kno		occurred at 19c. Licens		te and pla			e(s) and manner as ate signed (Month)	
	5 3		1 CKA	1	MD	l an		563	7				
	7		30. Name and address of berson wh	no completed cause of d	leath (Item 23a)						A	pril 6,	<u> </u>
			Dr. Kaplan, 181	ll Prince Pi	hilin D	rivo #3	27 - C)lnev	Mar	rvland 2	ንበጸን	2	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	10,00				<i>y</i> /			
	Registr	ar	APR 12 201	C Ducke	4. 4	10 mm							

State of Maryland / Department of Health and Mental Hygiene

		_1	For State State Registrar	•	ertificate of Deat	th R	eg. No. 2012				
П	Physicia	1/	1. Decedent's Name (First, Middle, Last) Cyrill Jenious			2. Date of Deat Month March 30					
	Medic Examin		a. Facility Name (if not institution, give street and		4b. City, Town, or Locate Hyattsvill	tion of Death	4c. County of Death Prince George's				
	Funeral Director		Heartland Healthcare of Social Security Number 6. Sex 172–24–2999	7. Age (In vrs. last birthda	y) If Under 1 Year If Under 1 Year Hou	nder 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign				
			Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits				
	Marylar 28a-f sl atified	Director	Maryland Prince George	's Hyattsvi	11e		1 🔀 Yes 2 □ No				
	th the 3a or 2		10e. Street and Number		10f. Zip Code	l .	10g. Citizen of What Country?				
	eath wi	<u>-</u>	6500 Riggs Road 11. Marital Status 12. Was E	ecedent Ever in U.S.	20783 3. Was Decedent of Hispania	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	nited States 14. Race - American Indian,				
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In proportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	è	1 Never Married 2 Married 1 1 If Yes,	es 2 K No	1 ☐ Yes 2 🛣 No Spe		Black, White, etc. Specify: Black				
15-0	72 hou n "natu Aedica	Completed	15. Decedent's Education (Specify only highest grade comple	ted) (G.	ecedent's Usual Occupation ive kind of work done during e. DO NOT use retired)	most of working	16b. Kind of Business Industry				
212	within /giene.			e (1-4 or 5+)	nistrative A		Government				
Maryland	oe filed intal Hy ced oth	To Be	17. Father's Name (First, Middle, Last) Bernard Sledd			Mother's Name (First, Middle, M lelaide Unknown					
anyl	hould I	Ì	19a. Informant's Name/Relationship (Type, Print)	19b. M			City or Town, State, Zip Code)				
e,	and 2 s Health em 27 i		Arthene Pugh/Cousin				hington, Maryland 20744 20c. Location - City or Town, State				
Baltimore,	Page 1 ament of hant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Removal 1 4 ☐ Donation 5 ☐ Other (Specify)	orn oraco	sposition (Name of crematory or other place) Memorial	04/12/2012	Suitland Maryland				
Balt	permit. Depart Import any inj		21. Signifiure of Funeral Service Ligensee	ent	22. Name and Address of Facility McGuire Funeral Service, Inc 7400 Georgia Ave., N.W. Washington DC 20012						
2	Physician Medical Examiner		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition and a second	Seps	Approximate Interval Between Onset and Death Onset and Death						
	icate be executed physician and sthe buriatement	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	to (or as a consequence of): Out of (or as a consequence of):	red Do	monia monta prascular à	Sisma sa				
120	ificate b ig physi as the b	1edic	d. 270	Tre 10 Section	e and	Justa C	7,5 (500)				
. Box 68	faw requires that the death certificate be executed as been signed by the attending physician and 2.2 should be detached for use as the buriat aresis.	ıysician/N	in the past 12 months?	outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year				
s, P.O.	res that the dec signed by the a d be detached f	d by Pr	Part II. Other significant conditions contributing	Baranomo-	_	Part I. 23e. Did to	bacco use contribute to the cause of death?				
Division of Vital Records,	ne law require e has been si age 2 should b	omplete	Diabetas Ma	ellitus Ty	IPO II	24a. Was a autop perfor 1 □ Yes	sy prior to completion of cause of death?				
tal F	sician: The certificate rector, pag	Be	25. Was case referent to medical examiner?		0.0	of Death (Check only one)					
of Vi	Physic rthis c eral dire	유	27. Manner of Death 28a. [I Inpatient 2 ER/Outpo	ne of 28c. Injury at	Nursing Home 5 Resid	ence 6 Other (Specify) ow injury occurred				
sion (To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director, After this certificate ha completed filled in by the funeral director, page	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Month, Day, Year) inju	M 1 Yes		treet and Number or Rural Route Number,				
Divi	irs after al Dire		4 ☐ Homicide determined	uilding, etc. (Specify)		City or Town					
	Hospi 24 hou Funer eted fill	Medical	(Check 2 Medical Examiner: On the	basis of examination and/or in	nvestigation, in my opinion, de	e and place, and due to the cau eath occurred at the time, date are	nd place, and due to the cause(s) and manner stated.				
	To the within To the Compl	Σ	only one) 3 Li Certifying Nurse Practio 29b. Signature and the of certifier	ier. To the best of my knowled	29c. License num	nber	29d. Date signed (Month, Day, Year) 3/30/12				
			30. Name and address of person who completed	cause of death (Item 23a) (Type)	1	Pockville 1	4D 2085Z				
	Sta		31. Date filed (Month, Day, Yeal)	2. Registrar's Sign dure	arles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:51 P_M Physician/ Month ANIL 2012 Frances Lucille Kidwell Medical 577 ation of Death 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Tedical 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Min (Month, Day, Year) Country) Director 1 □ M 2 💢 F 215-40-3828 70 10/11/1941 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location Stabbt-W 10a, State 10b. Count notified at Director 1 Yes 2X No Mechanics ville Maryland St. Mary's 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number Examiner must be items 23a Funeral 39220 Wisteria Court 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ò 1 Never Married 2 X Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Financial Finance and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Brady George F McKenze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health as
Important: If item 27 is
any injury or other traus 39220 Wisteria Court Mechanicsville, MD Thomas Joseph Kidwell, Sr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 4/20/2012 Brentwood, MD M00817 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 21. Signature of Funeral Service Licenses Echals 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Examiner Esquentially list so citions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequer Physician/Medical certificate be Box 68760 the use as attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death the the P.0. ed by the Part II. Other significant conditions contributing to de ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No has certificate or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work?
1 Yes 2 No Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29h. Signature and t 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) Name and address of person 3)eme Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	d / Depa	artment of Healt	th and M	ental Hyg	iene	
			State Registrar	Cer	tificate of Deat	th	R	eg. No. 2	2 13148
ı	Physicia Medic		Decedent's Name (First, Middle, Last) Gaither Wi	illiam	Kline		2. Date of Death	Pay 201	ar 9:50 P M
1	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locat			4c. County of E	
4	Francis		Meritus Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. las	st hirthday)	Hage:	rstown	8. Date of Birth		hington Birthplace (State or Foreign
	Funeral Director		219-20-0889 1X M 2 □ F 86	Yrs.	Months Days Hou		(Month, Day,	Year)	Country)
	d ow t	L	Usual Residence of Decedent	Town on Law			Oct. 27	,1925	Maryland
	arylan a-f sh fied a	Director	Maryland Washington	Town or Loc	Hagerst	own			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	he Mi	Dir	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	
	with s 23a lust b	Funeral	1206 South Point Drive		217	40		U.S	.A.
99	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 194 1 Yes 2 No 199 1 Yes, Give Married	13- I If	Vas Decedent of Hispanic Yes, specify Cuban, Mex	xican, Puerto R	ify Yes or No- lican, etc.)	Black, V	American Indian, Vhite, etc.
00	ours a	ted	3 🐒 Widowed 4 □ Divorced Year or Dates. ₩W	VII	Yes 2 No Spe	зспу.		Specify:	White
15-	72 hc In "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation ind of work done during i DNOT use retired)	most of workin	g	16b. Kind of Busine	ess/Industry
212	within giene.		Elementary/Secondary (0-12) College (1-4 or 5+)		Superinten	dent		Cons	truction
land	ould be filed d Mental Hy, marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Sherman A. Kline					laiden Surname) .ckenstaf	f
Ē	D L		19a. Informant's Name/Relationship (Type, Print) Gaither William Kline (Son)		g Address (Street and Nu Rainbow Ave				
ore,	of Hear		20a. Method of Disposition 20b. Pla 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cafe	ace of Dispos	sition (Name of	D		20c. Location - City	y or Town, State
ţi	. Page tment tant: I jury o		4 ☐ Donation 5 ☐ Other (Specify) Sale	em Uni cch C	ted Methodi: emetery	st Apr	il 18, 2012	Wolfsvi.	lle, Maryland
Ball	permit. Page 1 and 2 st Department of Health a Important. If item 27 is any injury or other trae		21. Signature of Funeral Service Licenses MO 14		Name and Address of Fa			ris Funera burg, Ma	al Home ryland 21783
-87	Physical		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final			h as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a conseque	ence of):	L. I new	Dis	ease	,	
		iner	if any, leading to immediate Cause Enter Underlying Due to (or as a conseque	ence of):	K. L ney Artery	, 0			
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		Arlery	1 1/	13605		
_	be exe	dical E	resulting in death) Last						
200	icate l	ledic	d						
Box 687	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral bifuector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	death 3 🗀	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.O.	at the		Part II. Other significant conditions contributing to death but not result	Iting in the ur	nderlying cause given in F	Part I.	23e, Did tob	acco use contribut	e to the cause of death?
ds, F	requires that the been signed by should be detac	ted by					1 ☐ Ye	es 2 🗆 No 3 🗆	Probably 4 Unknown
Division of Vital Records,	The law re te has be bage 2 sh	Completed					24a. Was an autops perform	y prior ned? deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sum \) No
tal	Physician; The this certificate al director, pag	Be C	25. Was case referred to medical examiner?			Death (Check			
Ž	Physic this or	은	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Impatient 2 ☐ E 27. Manner of Death ☐ 28a. Date of injury ☐ 2	R/Outpatien				nce 6 Other (S	pecify)
o uo	eath. or After th funer	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	injury	28c. Injury at work? M 1 🔲 Yes		8d. Describe hov	w injury occurred	
Divis	tal or Att rs aft rd al Direct ed in by		4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	2	8f. Location (Str. City or Town,		Rural Route Number,		
	To the Hospital or Attending Physician; The la within 24 hours aff is death. To the Funeral Director Affer this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowler 2 Medical Examiner: On the basis of examination a 3 Certifying Nurse Practitioner: To the best of my	and/or investi	igation, in my opinion, dea	th occurred at t	he time, date and	d place, and due to t	the cause(s) and manner stated.
	With with Com		29b. Signature and title of certifier There are the second secon	29c. License numb	796	29	9d. Date signed (Mi	onth, Day, Year)	
	1/1/		30. Name and address of person who completed cause of death (Item 2	23a) (Type, Pi	rint) 11 2 6	exctor	in cl	19217	40
37	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	A					

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Lola Irene Kline Physician/ April 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours **Director** 220-28-3417 1 M 2X F Yrs 96 Nov. 30, 1915 Maryland Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mernal Hygiene. Important if item 27 is marked other than "natural any injury or other traumatic events." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Smithsburg 1 Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 13428 Wolfsville Road 21783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: 3

Widowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Labor Book Binding Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Amos Kline Dorothy Alice Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13342 Wolfsville Rd. Smithsburg, Maryland 21783 Dorothy M. Kline (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crystall place)
Mark's Lutheran
Church Cemetery ⊠ Burial 2 □ Cremation 3 □ Removal from State 20, April St. Wolfsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee Davis Funeral Home MO1414 22. Name and Address of Facility J.L.12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or i that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ò in the past 12 months? Month Year Day Pregnant at time of death been signed by the a should be detached to ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform certificate 2 🗌 No Yes Yes funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: After 1 Natural 5 Pending work?
1 Yes 2 No Accident s after death Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F the only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) " By MN D0058726 4-17-2012 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) velle Warren MD Ventrie Ct Myersville 000 D 31. Date filed (Month, Day, Year State APR 2 6 2012 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Lee **Aloysius** 6:35 A Alton April Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Great Mills Chesapeake Shores Nursing Center 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Hours (Month, Day, Year) 01/28/1952 Director 60 217-60-6725 Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Lexington Park St. Mary's 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Completed by Funeral 23a USA 20653 45999 Great Mills Court an "natural", or items Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other than ed other than event, the N Ó Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ of Health and Menta item 27 is marked other traumatic e Richard Lee Ruth Aberdeen Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bruner/Sister 109 Kestral Way, Kathleen, GA 31047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Mattingley-Gardiner
Funeral Home, P.A.Crematory04/18/2012 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 21. Signature of Funeral Service Ligenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Year Other (specify) signed by the a 2 No 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No ပ္ To the Hospital or Attending Physis within 24 hours at er death.

To the Funeral Director: After this of completed filled it by the funeral directors. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Ceath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? injury 5 Pending 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2012 5:25 A Peter Frank Lloyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NMS Healthcare Hagerstown Washington Social Security Number 6. Sex 1 M 2 D F If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Birthpia Ohio Months Hours Jan. 15, 1951 61 Director 279-50-3223 Usual Residence of Decedent 28a-f show 10b. County 10d, Inside City Limits 10a State 10c. City, Town or Location at Director notified 1XXYes 2 No Virginia | Virginia Beach City Virginia Beach 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1325 Thamesford Drive 23464 death v items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? Black White etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 X Divorced Completed Year or Dates White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>Inventory Specialist</u> Medical event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ဂ Russell George Lloyd Marjorie Anne Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 325 Thamesford Drive Virginia Beach, Virginia 23464 Anita Giominozzo - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other April 9,2012 Boonsboro, Maryland Manor Cemetery nature of uner Osborne Arunerally Home, P.A. 425 S. Conococheague St.Williamsport,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiomyoram disease or condition Medical Due to (or as a consequen of): resulting in death) Obstructive Examiner D. SERSX LVONIC Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine sician and burial-transit SION Cause (Disease or iinjury that initiated events resulting in death) Last ev Due to (or as a consequence of): mellitus attending physician I for use as the buria D. abet Physician/Medical 15 Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 5 Other (specify) ed by the a signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 24 hours after death.

Funeral Director: After this certificate Yes 2 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Other: ျှ 1 Yes 2 🖵 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 06039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARID 21740 MURSHE 31. Date filed (Month, Day, Year) State APR O

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Naomi Mae Lorsong April 2012 4:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Denton Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 6, Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Min. 1 🗆 M 2 😾 F 194-16-0012 90 Director Yrs Oct. Penn. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits illed within 72 hours after death with the Maryland Director MD Caroline 1 🗌 Yes 2 🖵 No Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25830 <u>Beetree Road</u> USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) orth and Mental F. Y is mark it. Page 1 and 2 should be fili rtment of Health and Mental rtant: If item 27 is marked o njury or other traumatic eve 2 John Hill Violet Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis J. Lorsong/ Son 25830 Beetree Road Henderson. MD 21640 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Holy Cross Department of Important: If any injury or once. April 16, 2012 Greensboro, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility P.O. Box 160 Greensboro, MD 21639 21. Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No ò Month Day Vear Pregnant at time of death the detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Records, Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 Yes 1 🗀 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 1 Yes Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Doth nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? 1 🔲 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

12 20

-4

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 April Sharon Elizabeth McMillan 9:45 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21995 Baja Lane Great Mills St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours ay, Year) 1961 Maryland **Director** 213 80 8688 1 🗆 M 2X 🗆 F 51 March Usual Residence of Decedent or 28a-f show notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD St. Mary's Great Mills 1X Yes 2 ☐ No 5 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 21995 Baja Lane 20634 US "natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced Specify: Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Budget Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o James Allen Dickerson Ethel Clarise Bush other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 i Ethel C. Young/Mother 21995 Baja Lane Geat Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department Important: Is any injury or 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial April 21 Leonardtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 38675 Brett Way Mechanicsville, MD20659 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physicany Onset and Death arrest res disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Obesi law requires that the death certificate be executed 076010 and trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year the g Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform certificate I ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in muralistic data. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 7066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D. 22650 Cedar Lane Court Leonardtown, Md 31. Date filed (Month, Day State Registrar's Signat 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Munson 2012 8:33 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Boonsbero Memorial 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Jan. 30 Year 924 **Funeral** Age (In vrs. last birthday) 1 🛛 M 2 🗆 F Months Days Min 212-24-5253 88 Yrs. Mary Land Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Hagerstown Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21742 15914 Fairview Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) stock clerk retail sales Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy, Important: If item 27 is marked other any injury or other traumatic accounts. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Earl H. Munson Gladys Catherine Faith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16633 Shinham Road, Hagerstown, Maryland Lynn E. Munson - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State emetery, crematory or other place) Little 4 Donation 5 Other (Specify) 2012 Clear Spring, Maryland Rose Hill Cemetery 21. Signature of Funeral Service Liounsee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Proviician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 2 \square No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performe certificate I Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2. No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 🗌 No Accident Investigation To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RO93556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 opal Court Hagerstown Manaha

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Dara O Brici		1- For State Registrar	31	ale (n waryian		rtificate o	f Death	id Menta	air yg	iene Reg.	No. 20)12	131	58
Physici edical Exam		Decedent's Nam						<u></u>			Date of Death Month D	ay Year		Time of Death	
1		Barbara 4a. Facility Name			street and numb	per)	T	4b. City, Town, o	or Location of I		April 4, 2012	4c. County of			\dashv
		8656 Open	Meadow \	Vay				Columbia				Howard			
Funeral Director		5. Social Security 015-24-9	364	6. Sex		Age (In yrs. I	•	If Under 1 Ye Months Da		24Hrs. 8 Min.	3. Date of Birth(9. Birthpla Foreign Country		
Any		Usual Residence of 10a. State	10b. County			10c. City	, Town or Local	tion					10c	d. Inside City Limi	iits
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vith the Maryland 123a or 28a-f show 2 notified at once.	٥)pen Me	ado					1045			United States o- 14. Race - American Indian, Black,			
or item	Funer	11. Marital Status 1 Never Marr		arried	12. Was Deced Armed Force 1 Yes		If Yes, specify Cuban, Mexican, Puer				rto Rican, etc.) White, etc.				
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11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. arked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Completed	Elementary/Sec		0.1, 0.1.1	College (1-4		during m	nost of working lift	e. DO NOT us			16b. Kind of Business/Industry Grocery			
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- 5 5 5 5		20a. Method of Disposition											210		\dashv
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Baltimore permit. Pages 1 a Department of He Important: If its		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Facility												y FH Inc	5.
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												MD 21043	3
Physician /Medical		failure. List or	nly one cause	on eac	h line.			iovascular D		ulac or re	spiratory arrest,	snock, or near		oproximate Interv etween Onset an Death	
≛xaminer		Immediate Cause or condition result			ue to (or as a co			iovascular D	isease			-	_	2000	\dashv
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8760 tificate b ng physicas the buy		IF FEMALE: 23b. Was decedent		10	23c. If yes, out			etal death 3	Ectopic p	regnancy		23d, Date of d Month	lelivery Day	Year	
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit	Physician/	past 12 month 1 Yes 2 ✓		known	4 Pregnan 9 Unknowr	tattime ofde n	noth -	ther (Specify)					,		
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of Vital Records, P.O. By Physician: The law requires that the flow their certificate has been signed by meral director, page 2 should be detach meral director, page 2 should be detach	Completed							-		_	24a. Was an autopsy performe	pri ed? de	or to compleath?	y findings availab	
al Remit The strift can tron, pa	Be Co	25. Was case refer	rred to medica					26.Plac	e of Death (Ch	heck only		No 1	✓ Yes	2 No	\dashv
of Vita ing Physici After this co uneral direct	IO B	examiner? 1 ✓ Yes	2 No	Ho		atient 2] ER/Outpatient		Other ₄ N	Nursing H	ome 5 Re	sidence 6 🗸	Other: Sce	ene	
	on:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred											t	_	7
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Division pital or At ours after direct fitted in by	ertif	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or or Town, State)										or registry	odio ridiliber, oli	,	
the Hoo hin 24 h the Fun upletely	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.											use(s)	_		
To with	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo									1 (Month, L	Day, Year)	\dashv			
	O.C.M.E. April 5, 2012									2					
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	tate		ithe Day: Year)	0 2	17 7 20 20 2	strar's Signati	ure A	arke	-						\dashv
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Smith Palmer 16, 8:20 p.nM. Jean April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chaptico St. Mary's <u>36111 Willow Glen Lane</u> 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Funeral Months Director 109-18-3442 1 □ M 2 💢 F Usual Residence of Decedent 96 03/16/1916 Maine 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 No Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral 36111 Willow Glen Lane 20621 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married b Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Yes Give 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Flementary/Secondary (0-12) College (1-4 or 5+) 12 permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other to any injury or other traumatic event, the once. Private Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Rodney Hamilton Smith Helen Florence Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelby P. Guazzo/Daughter 36184 Willow Glen Lane, Chaptico, MD 20621 20a. Method of Disposition 20b. Place of Disposition (Name of cemeters, cremators or other place)
United States
Military Academy Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/04/2012 West Point, New York Signature Funeral Service Lic. Brinsfield Funeral Home, P.A. MD. 20650 22. Name and Address of Facility Jr. M00052 22955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) us to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and burial-trar resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IE EEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months? Day Pregnant at time of death 2 X No 1 ☐ Yes 2 ☐ Unknown Unknown or Attending Physician: The law requires that the after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: after death. Director: After Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa ure and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boyd II, $_{
m M.D.}$ William D. 25365 Point Lookout Road, Leonardtown, MD

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

APR 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #9 PER EL G928 6/27/12 TRT Department of Health and Mental Hygiene Certificate of Death RegistraMEND#7+8perFH,4/23/12;BMW,McCo 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 10200 M mar 28 20/2 50 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 9 1000p DRK 4 2 3 Sucos Cross 9. Birthplace (State or/Foreign If Under 1 Year If Under 24 Hrs. 82 Date of Birth 6. Sex Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 38 SOUTH CAROLINA 73_{yrs} Hours 224-44-0229 1 🗆 M 2 🗶 F **Director** 09/29/1928 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County at Director 1 🗌 Yes 2 🗓 No event, the Medical Examiner must be notified Beltsville Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò U.S.A. Funeral items 23a 20705 11320 Cherry Hill Road. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 14. Race - American Indian Black, White, etc. ö 2 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify Black "natural", 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare emit. Page 1 and 2 should be filed with eportment of Health and Mental Hygient important: If item 27 is marked other the my injury or other traumatic mose. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Colene Shannon Finley Yarborough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11320 Cherry Hill Rd., #201. Beltsville, MD 20705 Cheryl McCorkle - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 04/14/2012 | Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service License 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final HEMMORAGE Ph_ician/ SUBDURAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions 19/ Examine Due to for as a consequence of cause. Enter Underlying use as the burial-transit DEMENTIA Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) 30 attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months?
1 Yes 2 No 4 Pregnant Pregnant at time of death signed by the at the detached for been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Vunknown MELLIT 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an HYPOTENSION autopsy performed funeral director, page 2 death? 25. Was case referred to medical examiner?
1 1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 [ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this ampletely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: Time injury P M 1 Natural 5 Pending 1 Yes 2 No 03,08,12 FAL 1600 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 1500 FOREST GLEN RD CROSS HOSPITAL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signatur 2012 D32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 M.D.Suresh K. Gupta, Date filed (Month, Day, Year) APR 12 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jane Peters April 2012 9:53 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1025 Pope Ave. Hagerstown Washington Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 205-18-0499 1 □ M 2 **X** F 85 July 24,1926 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f shorement must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1025 Pope Ave. U.S.A. 21740 Page 1 and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Medical Examiner ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Teacher Education other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward R. Taylor Jeannette Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry H. Peters/Son 11215 Shalom Lane, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4/11/2012 Rose Hill Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel 22. Name and Address of Facility 1601 Pennsylvania ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one dat is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. ancer-Frimas disease or condition rnonths Medical resulting in death) **Examiner** Metastatio months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi Cause (Disease or injury that initiated events months Due to (or as a consequence of) resulting in death) Last attending physician /Medical Cancer letasta Hospital or Attending Physician: The law requires that the death certificate be months Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Yo 3 Ectopic pregnancy
5 Other (specify) ō Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ Unknown the detached g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No certificate 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Hospital: Other: 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of 29d. Date signed (Month, Day, Year) 2115203 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 747 Northern Are. Hagerstown Spencer CRNP Banbara MD 21742

DHMH 17 Rev 06-201

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day NEWTON PAINE HENRY Apri 13 2012 6:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot <u> Cenesis HealthCare</u> The Pines <u>Easton</u> If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) 7 / 31 / 1 9 1 5 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 🔀 M 2 🗆 F Country) **Director** 001-10-9017 96 Massachusetts Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at Director 1 ¥ Yes 2 □ No Easton Talbot MD 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? Funeral 21601 items 23a 106 West Earle Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 10' 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Henry Paine Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter G.E.D. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental I item 27 is marked o မ Grace Gladys Brooke Sherman Roger Paine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21601 6360 Country Club Dr., Easton, MD Joyce Paine Lewis/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4/16/12 Cambridge, 4 ☐ Donation 5 ☐ Other (Specify) Mid Share Cremation Cutr. . Signature of Euneral Service Licensee 22 Name and Address of Facility Mid Shore Cremation Cntr. Cambridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Pnysician/ Medical resulting in death) Due to (or s a consequence of): **Examiner** 05 1230 Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Unrector After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 $M_{\rm M}$ OBERT 508 Year) 2. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

7

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:27 April 18 William Blount Rodman V Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 44552 Redwood Lane California If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) **Director** 231-56-0740

Usual Residence of Decedent 1 3 M 2 D F 68 Yrs 08/ 06/ 1943 Virginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 x No St. Mary's Maryland California 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe must be Funeral items 23a 20619 United States 44552 Redwood Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian 11. Marital Status Examiner rmed Forces?

X Yes 2 \(\subseteq \) No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give 1972-1994 1 ☐ Yes 2 🔽 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Flight Officer US Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Noble Rodman IV Susan William Blount 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau 44552 Redwood Lane, California, Maryland 20619 Kathleen A. Rodman-Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Tcremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/20/2012 Charlotte Hall, Maryland Brinsfield-Echols 22. Name and Address of Facility Brinsfield Funeral Home, Kathleen A. Santivasci M00872 Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proviciun/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? has page 2 death? 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending s after death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in the control of the cause (s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address/of/person who completed cause of death (Item 23a) (Type, Print) 10 eme 20650 40900 Merchants Lane, Suite 205, Leonardtown, MD Jennifer Schmidt, D.O.

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year APR 1

9

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ amos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kton 5. Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 80.52 Months Hours (Month, Day, 1 □ M 2 🗹 F **Director** 14 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M dical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** avre-de 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2. Married Baltimore, Maryland 21215-0036 1 ✓ Yes 2 ☐ No Specify: Tuerto Rican Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Garment reamotress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <amos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State H Kaymonds 4 Donation 5 Other (Specify) 21. Signature of Fun mil Service Licensee 10462 STONX NT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or lingury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 M No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗹 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 6 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ April 7, 1:00 AM Phvllis R. Sochor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) Min Hours 156-07-0635 1 M 2 X 91 12/02/1920 New Jersev Usual Residence of Decede 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2X No Severna Park Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 21146 43 W. McKinsey Road 317 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public School System Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Irving Lewis Randall Gladys Starkweather 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Moss Haven Ct, Annapolis, MD 21403 Richard Sochor/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4/10/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Signatury of Funeral Service Licensee Holloway Funeral Home Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRI LLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DYSLIPIDEMIA 24a. Was an autopsy performed Yes 2, 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 5 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural work? 1 \(\sime\) Yes 2 No

physician and s the burial-tran the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 s certificate has b director, page 2 s this After within 24 hours after death

To the Funeral Director: /

Funeral

Director

28a-f show

must be notified

Medical

the

other traumatic

injury or

Physician

Medical

Examiner

any inj

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physician/Medical Completed by Be 횬 Certificate: 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

BA S

State Registrar

only one) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVULUR MADITAN 2001 MD 31. Date filed (Month, Day,

32. Registrar's Signature

Certifying Nurse Practitionery To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ April 9. 6:20 рм Edward Schweinhart Maurice Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens at Riderwood Village P.G. Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) **Director** 401-28-5807 1 🖾 M 2 🗀 F 88 Jan. 19, 1924 ΚY Usual Residence of Dece 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? s 23a on c must b Funeral 3116 Gracefield Road, 20904 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. rmed Forces?

Yes 2 \sum No. Black White etc. by 1 Never Married 2 Married White If Yes, Give Year or Dates, 1943-46 1 ☐ Yes 2 🗷 No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Management Analyst US Dept. of Commerce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Elmer Otto Schweinhart Josephine Bernadette Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Schweinhart/Son 15225 Manor Lake Drive, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, April 1 X Burial 2 Cremation 3 Removal from State 13, Resurrection Cemetery 4 Donation 5 Other (Specify) Clinton, MD 2012 of Funeral Service Lice Signati Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 mos Immediate Cause (Final Physician Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burnal-trans Due to (or as a consequence of) Physician/Medical use as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnant at time of death Day the ; been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has I autopsy performed' certificate Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director; A bletely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State

within 2.

To the Foundlet (o+1

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

30. Name and

(Check

only one)

Julaine

29b. Signature and title of certifier

address of person who co

Harding, CRNP

ause of death (Item (Sa) (Type, Print)
3110 Gracefield Road, Silver Spring, MD 20904 Month, Day, Year 32. Registrar's Signature APR 12 2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date sjigned (Month, Day, Year)

12

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12ay April 201°2 7:47 Ам Benjamin Everett Staton Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline 203 Riverview Gardens Denton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Months Days 1 XM 2 - F Hours Min July 14. 54 1957 Yrs Director 216-74-6425 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director 1 X Yes 2 □ No Denton Maryland Caroline 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21629 203 Riverview Gardens 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceden Evol Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 X Never Married 2 Married þ 72 hours after 3altimore, Maryland 21215-0036 ian "natural", o Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Line worker Cannery 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Elizabeth Weikle Emory Lee Staton, Sr. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n Denton, Maryland 203 Riverview Gardens Deborah G. Smullin/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1

Burial 2

Cremation 3

Removal from State 4/18/2012 Dover, Delaware 4 Conation 5 Other (Specify) Capital Crematory Moore Funeral Home, P.A. Signature of Funeral Service Licer 22. Name and Address of Facility Denton, Maryland 21629 12 South 2nd Street 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PROBATILE MOTASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to (or sels consequence of, many, leading to immediate cause. Enter Underlying -transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical certificate be Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 5 Other (specify) Pregnant at time of death signed by the a Id be detached f g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an has performed I or Attending Physician: The safter death.

Director: After this certificate by Yes 2 X 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar only one)

3 29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

609

32. Registraes Signa

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

DONTON,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a, pt. II, g927 5-11-12, per me sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:45 Betty Lorraine Smith April Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Envoy of Denton Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Yea March 26 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F Director 79 Virginia 223-46-8330 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Delaware Kent Harrington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3598 Burnite Mill Road 19952 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 ₩ Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Famil_v 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elizabeth Kelso Clarence Oscar Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond L. Smith, Jr./Son 3598 Burnite Mill Road Harrington, Delaware 19952 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) E.S. Veterans' Cemetery 4/17/2012 | Hurlock, Maryland Signature of Funeral Service Lizer e 22. Name and Address of Facility Moore Funeral Home, P.A. Mou andolo 12 South 2nd Street Denton, Maryland 21629 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final Physician ARTERIOSCLEROTIC CARDIDVASCULAR IRCUTE disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** HYDERTENSIVE CARDIOVASCULAR HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth
4 Pregnant a
g Unknown in the past 12 months? Day Month Year Pregnant at time of death 2 🌇 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? ronic obstructive Lung Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚰 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident Investigation the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29c. License number

State Registrar 31. Date filed (Month, Day, Year

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DENTONI MD21629

Centy ME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Anthony G. Shufelt Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist flospice Care Baltimore TOWSON 1 Year If Under 24 Hrs 5. Social Security Number . Age (In vrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y 1 □XM 2 □ F Days Hours Min 221-40-2657 59 Yrs Director 1952 Delaware Nov. Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Essex Baltimore 1X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 United States 511 Delaware Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Deceden 2. Armed Forces?

1 Yes 2 No Examiner . or Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Masonry at BWI Elementary/Seconday (0-12) College (1-4 or 5+) the Mason 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lennon Shufelt Janet Lee Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Delaware Ave., Essex, MD 21221 Colleen Shufelt/Spouse other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Federalsburg, ō 04/11/12 4 ☐ Donation 5 ☐ Other (Specify) Hill Crest Cemetery injury 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 Signature of Funeral Service Licensee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Metastatic Savamous Cell months Orodharynx disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached f Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Tother (Specify) NOSDICE 1 Tes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this : After this tuneral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Example: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title gf certifie

Christine Chune

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

M.D.

N.

32. Registrar's Signatu

Broadi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

401

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore

29d. Date signed (Month, Day, Year)

21231-2410

2012

Hospital or Attending Physician: Division of Vital Director: hours after death. within 24 hours aft To the Funeral Di completely filled in

> 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)

and manner stated.

Registrar's Signatur

determined

Homicide 29a. Certifier 1

29b. Signature and title of certifier

APR 24

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

April 21, 2012

OCME

Found: Residence

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Medical

State

Registrar

ustin David Sta	imb	augh Si 1- For State	tate of Maryla		artment of <i>rtificate of</i>		d Mental			201	2 1316		
Physici	an/	Registrar 1. Decedent's Name (First, Midd	le,Last)		Tillicate of	Death		2. Date of De	Reg. No ath	201	3. Time of Death		
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		4a. Facility Name (if not institution	_	mber)	- 1	b. City, Town, or		eath		c. County of Death			
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Funeral Director	i i	5. Social Security Number		7. Age (In yrs. I		Months Day		Min		I/DD/YYYY) 9. Birt Foreig	ın		
		219-25-9405 Usual Residence of Decedent	1 X M 2 F		2.2 Yrs.			Sept	. 21	, 1989 co	untry) PA		
, and		10a. State 10b. County		10c. City	, Town or Locati	on					10d. Inside City Limits		
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Maryl	Director	10e. Street and Number				10f. Zip Code			-	tizen of What Cour	ntry?		
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5-00; led with Hygiene other t	Completed	12 17. Father's Name (First, Middle	, Last)		Car	rpenter	18.Mother's Na	me (First, Middle,		onstruc	CION		
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ID 21215-00%; should be filed with; and Mental Hygiene, 77 is marked other that	٩	19a. Informant's Name/Relationship (Type, Print) David W. Stambaugh/Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 3803 Rockdale Rd. Manchester MD 2											
≥ 5 4 5 5		20a. Method of Disposition	ilibaugii/ f	20b.	Place of Disposi	tion (Name of cer	netery.	Date		Location - City or			
Baltimore, permit. Pages I ar Department of Hee Important: If ite	~	1 X Burial 2 Cremation	n 3 Removal fro	om State Mt	crematory or oth	er place) Unite	d Ar	or. 20,					
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		used the death.	. Do not enter th	e mode of dying,	such as cardia	c or respiratory ar	rest, sh	ock, or heart	Approximate Interval Between Onset and		
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Inju		0.						Death		
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OX 6 eath ce attend for use	sici		4 Pregna	ant at time of de	ath 5 Oth	er (Specify)			1				
J. B.	Phy	Part II. Other significant condit			esulting in the ur	nderlying cause g	iven in Part I.	23e. Did	obacco	use contribute to t	he cause of death?		
ires that signed I be deta	d by							_ 1 _ Ye	s 2	No 3 Prob	ably 4 🗸 Unknown		
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rision r Attender er death irector:	ertification:	2 🗸 Accident Inves	stigation	of Injury - At ho	ome, farm, street	t, factory, office bu		vehicle acc 28f. Location (and Number or Rur	al Route Number, City		
Dital on ours aff	E S	4 Homicide deter		Local Stree	et			or Town, Beckleysville	State) Road	& Falls Road, M	anchester, MD		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ical C	(hysician: To the best										
To the To the comp	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, L												
Morris		110	111-1	CT	1	0.C.N	Λ.Ε. _{ΟC!}	ÆF.		il 15, 2012			
loth		30. Name and address of person	who completed caus	e of death (Item	23a)	<u>U.l</u>		71to					
		Theodore M. King, Jr.				00 W. Baltim	ore Street,	Baltimore, M	D 212	23			
St Regist		31. Date filed (Month, Day, Year) APR 2 6 2012	32. Re	gistrar's Signatu	arked								
	-		DOM:										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Marc 10ri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Abingdon force Har Merrick Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Country) - 985 Director 1 X M 2 - F -19-1935 Missouri 76 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State Examiner must be notified at Director 1 X Yes 2 No Abingdon Harford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral SA 100 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. "natural", Specify: White Completed 3 Widowed 4 Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) relephone mmunications Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche should and Me 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Heath ar
Important: If item 27 is
any injury or other trau Abingdon Jannie Squibb Merrick Way 20b. Place of Disposition (Name of cemetery, crematory or other place), 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State -ewisburg 4 Donation 5 Other (Specify Entembrient 4-12-2012 muscleum 21. Signature of Funeral Service Licensee 22. Name and Address of Facility wordow Home 24901 23a-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL FA. lune A Ph. sician

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A Ph. s Year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician ar Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year 2 No 1 Yes 2 9 Unknown the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDO MY A PAThy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy perform death' Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 24 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi D35889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUL AIR MD SPANY 615 MACPHAIL

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1 Decedent's Name (First Middle | ast) April Physician/ 2012 5:05 A M Robert Elward Townsend Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 26242 Gardiner Court Mechanicsville If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Days (Month, Day, Year) 1 🌠 M 2 🗆 F Director 577-84-6675 51 03/28/1961 Clinton, MD Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 26242 Gardiner Court USA 20659 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give þ filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates ntal Hygiene.
ed other than "natura"
event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Landscaping / Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Landscaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is medany injury or other? ပ Richard Ernest Townsend, Sr. Marie Annette McLean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Jean Townsend / Wife 26242 Gardiner Court, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Crem 04/16/2012 | Charlotte Hall, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Signature of Juneral #M00817 30195 Three Notch Rd., Charlotte Hall, Part I. Enter the disease, or eximplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, frany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or se a consequence of): the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death within 24 hours a er death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached. 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 20 No Hospital Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis of examiner and a management of the cause (s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ed cause of death (Item 23a) (Type, Print) 3200 30. Name and address of person M 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0, 2012 04:15A Dorothy Ellen Webb Taylor April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hartley Hall Nursing & Rehab Worcester Pocomoke City 8. Date of Birth (Month, Day, Ye Aug. 8 If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year Months Virginia 1929 Auq. 82 Director 225-40-4408 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Yes 2 No Pocomoke City MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21851 USA Cambrook Drive 2628 items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mabel Parker Sidney Hopkins Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $2\,1\,8\,5\,1$ permit. Page 1 and 2 s.
Department of Health a
Important: If item 27 i
any injury or other tra Alvin Taylor/ Husband 2628 Cambrook Drive, Pocomoke City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Downing's Cem. 4/13/2012 Oak Hall, VA Signature of Fun // Service Licensee 21851 22. Name and Address of Facility Holloway Funeral Home, P.A., 107 Vine St., Pocomoke, MD 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on social line. Interval Between shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) a Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No ō Month 5 Other (specify) Pregnant at time of death signed by the a Id be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director. 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Knursing Home 5 - Residence 6 - Other (Specify) 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Actifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nature and title of certifier 4-10-2012 AR AD 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) BA 4 31. Date filed (Monta egistrar's Signatu State Darke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0:00 M Claude Line Thomas, Jr. April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14427 Paradise Church Rd. Hagerstown Washington County 8. Date of Birth Aug. 22,1926 Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 220-26-5599 85 Maryland 1 XM 2 □ F 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Washington County Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14427 Paradise Church Rd. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No Specify. White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Crane Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Line Thomas, Sr. Annie Mae Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary W. Thomas-son 1970 Maraposa Dr. Chambersburg, PA 17201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Beaver Creek Cemetery 4-11-2012 Beaver Creek, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licer Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) OROMARY Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death nan 3 Ectopic pregnancy 5 Other (specify) ___ 23d. Date of delivery hs? Month Day t conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical **Examiner**

Physician/

Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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10a. State

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Department of I Important: If ite any injury or ot

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other traumatic event,

with the Maryland

death

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit

The law requires that the death certificate be

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within 24 hours after death.

To the Funeral Director: After this

To the Hospital

filled in by the

Medical

29a. Certifier

Date filed (Mo)

Box 68760

Division of Vital Records, P.O.

Examine Physician/Medical þ Completed Be ပ Certificate:

ı	
	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
	Part II. Other significan

1 Yes 2 No 3 Probably 4 Unknown

eck on	2 JZN NO

24b. Were autopsy findings available prior to completion of cause of death?

1 Nes 2 □ No

							1 100 2 224101
25	. Was case referred to medical examiner?	Ü				26. Place of Death (Che	ck only one)
	1 ☐ Yes 2 No	Hos	spital: 1	ER/Outpatient	з 🗆	DOA Other: 4 I Nursing H	lome 5 Residence 6 ☐ Other (Specify)
1 2	. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be		28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	1 286 Place of Injury . At home form street				ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lou.	COLUMN	Tysician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	(Check	2 🔛 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	only one)	3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b.	Signature an	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)										
		nd / Howard on	050630626	April 9, 2012										

30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Joseph 4. Stewant 1200 4 nessono

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 George Raymond Teague 0645 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Ceci1 E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours July 25, Year 927 Min Maryland 84 **Director** 218-18-8085 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director E1kton 1 Yes 2 X No Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 E1k Forest Road 21921 United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc 1 Never Married 2 X Married Yes 2 X No þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche O'Berry Harold E. Teague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Teague/Wife 701 Elk Forest Road, Elkton, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gilpin Manor Memorial Park 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Elkton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death COLON CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and-tran Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe Yes 2 No certificate 1 ☐ Yes 2 ☐ No this certific ral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ 1X Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Coertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) MD D0062140 U gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KITA-W MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 2 6 2012

32. Registrar's Signature

AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD 21915.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 Gloria Jean WALKER 30PM 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 925 Maryland Avenue Hagerstown Washington . Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. I 1 M 2 XF Months Days Hours Min. ^Y1956 219-66-0028 55 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10d. Inside City Limits Director notified 1 X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 925 Maryland Avenue 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married þ Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Mental Hygiene. homemaker her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Luther Robinson, Sr. Shirley May Dickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 John Walker - husband 925 Maryland Ave., Hagerstown, Maryland 21740 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. ò cemetery, crematory or other place 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State April₂₀₁₂ 4 Donation 5 Other (Specify) Hagerstown Crematory Hagerstown, Maryland MINNICH FUNERAL HOME 21. Signatur of Funeral Service Licensi 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atheronder disease or condition resulting in death) min Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine cause. (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months? 4 Pregnant Month Day Year Pregnant at time of death 2 No detached g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has funeral director, page 2 autopsy perform 2 No 20 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗶 Residence 6 🗆 Other (Specify) Hospital: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after deat Funeral Director: in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, မ D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nell Street Hagestern 902 2 A 68 State Registrar

			Please Type or Pr					-	_	e.
			State of N	/laryland /			lealth and M	lental Hy	giene	
	٠,		Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rtificate of	Death	2. Date of De	Reg. No. 20	2 3 Time of Death
Phys			Winford Howard Wi	1100				Month April	Day Ye	
	edica mine		4a. Facility Name (If not institution, give street and number			4b. City, Town, o	or Location of Death	APLII	4c. County of E	
		Ė	31454 Eden Allen Road			Eden			21822	
Fune			16M 2□F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Birthplace (State or Foreign Country)
Direct	or		217-05-0762 Usual Residence of Decedent	93				Oct. 5	, 1918 V	irginia
ryland how			10a. State 10b. County	10c. City, To	own or Lo	ocation				10d. Inside City Limits
ne Ma 8a-f s		Director	Maryland Somerset	Ec	len			,		1 ☐ Yes 2 ₹ No
21215-0036 I within 72 hours after death with the Maryland jiene rithen "natural", or items 23a or 28a-f show trithen traminer must be notified at			10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
leath ns 23		Funeral	31454 Eden Allen Road 11. Marital Status 12. Was Deceder	nt Eve r∕ in U.S.	13.		822 Hispanic Origin? (Sp.	ecify Yes or No	U.S.	American Indian,
or iter			1 Never Married 2 Married 1 Yes 2	5?/		If Yes, specify Cub	dispanic Origin? (Sp an Mexican, Puerto	Rican, etc.)		Vhite, etc.
5-0036 72 hours af natural", or sileal Exami		g p	3 Widowed 4 □ Divorced If Yes, Give Year or Dates						Specify:	White
filed within 72 h Hygiene. other than "natu		Completed	15. Decedent's Education (Specify only highest grade completed)		6a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kind of Busine	ess/Industry
withii iene. than		E O	Elementary/Secondary (0-12) College (1-4o	r 5+)		gineer	u)		Televi	sion
e the Hyger		Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maiden Surname)	
Tarylan 2 should be and Mental Is marked o		2	Robert Samuel Wiles				Bess	ie Maha	ffey	
Mar d 2 sho th and 7 Is m		- 1	19a. Informant's Name/Relationship (Type. Print)	1	19b. Maili	ng Address (Street	and Number or Rur	al Route Numb	er, City or Town, Sta	te, Zip Code)
e, l 1 an Heat em 2			Lesley Ashley Daughter 20a. Method of Disposition	20b. Place	of Dispe	osition (Name of	i	, Hebro	on, Md. 21 20c. Location - City	
00			1 ☐ Burial 2 ☐Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	te	-	matorý or other pla cy Cremat	i	1/12	Salisbury	. Mđ.
	9	Ì	21. Signature of Funeral Service Licensee	5432		2. Name and Addre			uneral Ho	•
Depara any i	8		Jan 2/2 1	M00295					ss Anne,	Md. 21853
			23a. P. of . Enter the disease, or complications the cause of ck, or heart failure. List only one cause on each	line.		^	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
Physicia /Medic			resulting in death)	ovgent as a consequence		Mart	tai/u	re		years
Examin				1471	000).					11080
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence	ce of):	. 0		//	/	7-1
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death certificate be e attending physiciar of for use as the burian	:	Physician/Medica	d							
ath cert		J.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom 1 □ Live hirth	ne pf pregnancy 2 ☐ Fetal dea		⊒Ectopic pregnanc	v		23d. Date of	
e dear e dear he att		Sicie		at time of death		Other (specify)			Month	Day Year
v requires that the debeen signed by the should be detached	i		Part II. Other significant conditions contributing to death	but not resulting	a in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
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ecor law req as beer 2 shou		lete						24a. Was	an 24b. Wer	e autopsy findings available
The lar	,	Completed						auto perfe 1□ Yes	ormed2/ deal	
On Or VITAI KEC ding Physician: The lav h. After this certificate has funeral director, page 2.3		Be C	25. Was case referred to medical examiner?				26. Place of Deat			
Or VITA Physician: rthis certific ral director,		9	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa 27. Manper of Death 28a. Date of Ir		Outpatie	III JU DON			idence 6 Other	Specify)
On Iding h. After		tion		Day Year)	Injury	Wo	rk?	260. Describe	how injury occurred	
JIVISION I or Attending after death. Director: After in by the fune	.	Certification:	3 Suicide 6 Could not be 28e. Place of	injury - At home, etc. (Specify)	, farm, st	reet, factory, office		28f. Location (Street and Number o	or Rural Route Number,
ital or ral Direction led in		Cer								
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the be 2 ☐ Medical Examiner: On the basis and manner	st of my knowled of examination	dge, dea and/or ii	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	and due to the red at the time	e cause(s) and manne , date and place, and	er as stated. I due to the cause(s)
To the vithin :		Me	29b. Signature and title of certifier	/		29c. Licens			29d. Date signed (A	
			I licht I		MD	Dex	5993	/	4-10-	-12
XUID			30. Name and address of person who completed cause of	f death (Item 23	a) (Type	Print)	1	017		Anne Md 2185
	Stat		31. Date/filed (Month, Day, Year) 32. Regi	strar's Signature	YOC	34 MIT	. Vernon	Kd ti	rincess 1	Anne Mdd 185.
Reg	istra	-	APR 1 2 2012	_		bake				
	_	_	1901							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year April John Reed Warrenfeltz 15, 7:20 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Washington **Examiner** 11208 Robinwood Dr. Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) April 22,1945 1X M 2 □ F Months Hours 220-42-5472 **Director** 66 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Medical Examiner must be Funeral 23a 11208 Robinwood Drive 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Army
If Yes, Give Black, White, etc. þ "natural", or 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance City Water Department 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Donald R. Warrenfeltz Caroline Reed 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Ann Whittington 11202 Robinwood Drive Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 18, cemetery, crematory or other place)
• Paul's Lutheran
urch Cemetery 1 X Burial 2 Cremation 3 Removal from State Leitersburg, Maryland 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): arteny descesse disease or condition resulting in death) MIINS Medical Examiner onsel- Dialites 54 LOWS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day signed by the at Id be detached fo 9 🗌 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 2 No 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 2 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 3a) (Type, Print)
- 368 mills Strul-Hagertton MD 2/740. gn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 6

DHMH 17 Rev 7/2009

Registrar

		1- For State Registrar				tificate of	Health and Mer Death		Reg	g. No.	201		131
ysici: xami		Decedent's Name (First, Middle David	die,Last)	Me sel-			i	Date of Death Month April 16, 20	Day	Year		e of Death 15 hrs
		4a. Facility Name (if not instituti	on, give	street and numb	Mark Der)	41	Alexande o. City, Town, or Location		April 10, 20		ounty of Dea		
		Millers Island Road 8	Bayli	ight Avenue		:	Millers Island				timore Co		
eral ctor		5. Social Security Number	6. Se		Age (In yrs, la	ast birthday)	If Under 1 Year If Und Months Days Hour		8. Date of Birth	(MM/DD	Fore	ign	(State or
Clor		219-54-3877 Usual Residence of Decedent	¹ X	M 2F	56	Yrs.			Oct. 11	195	5	ountry) Mary	land
Amy		10a. State 10b. County			10c. City,	Town or Locatio	n					10d. lr	nside City Lin
f show	ō	Maryland Bal	timo	ore	Ede	gemere						1	Yes 2 X
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatie event, the Medical Examiner must be notified at once.	Director	10e. Street and Number					10f. Zip Code		10	g. Citizen	of What Co	untry?	
23a c		2809 2	2nd	Street	ent Ever in II	S 13 Was	21219 Decedent of Hispanic On		cify Yes or No-	14	LISA Race - Ame	erican Ind	ian Black
r item	Funeral	C	farried	Armed Force			s, specify Cuban, Mexical			'-	White, etc.	i loair illa	ian, black,
al", o	by F			If Yes, Give Yeer or Dates:		1 \	es 2 x No specify	y:		Spe	ecify: V	white	9
Exam	pe	15. Decedent's Education (Spe					Usual Occupation (Give			16b. Kind	of Business	/Industry	
dical	Completed	Elementary/Secondary (0-12)	'	College (1-4	or 5+)	(Trans	uck Driver			c	Supply	Com	oanu
other he Me	Con	17. Father's Name (First, Middle	, Last)					er's Name (F	First, Middle, M			COM	Daily
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7 is ma	유	19a. Informant's Name/Relations				19b. Mailing /	Address (Street and Nu			•			
traum		Brenda C 20a. Method of Disposition	A_	lexander	20b. P		8492 Laurel on (Name of cemetery,		#B Pas	aden 20c. Loc	ation - City o	2112; or Town, S	2 State
other If		1 Burial 2 Cremation	-	Removal from	State S	rematory or other Stanis	laus Cem	4/23	/2012	Balt	imore	Mary	yland
ortan		4 Donation 5 Other S 21. Sig ture of Fune Service		ee /		22. Na	me and Address of Facilit	ity				_	
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cian		23a. Hart I. Enter the disease, or	mpli	ordio e that caus									
lical	- 1	failure. List only one cause	on had	ch line	sed the death.	Do not enter the	mode of lying, such as o	car liac or r	espira ory arres	i, snock,	or hear		een Onset ar
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■ Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 Yes 2 X No If Yes, Give Year or Dates.	0	1 Yes 2 K No		Hican, etc.)	Specify:	k, White, e Wh	etc. nite	
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7 # = =		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm Specify)	n, street, factory, office		28f. Location (Str City or Town		or Rural i	Route Num	nber,
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DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

APR 2 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** BARNER APRIL CHARLES 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Usual Residence of Decedent Director 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland Town or Location 10b. Count 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director timo MARYLAND 10g. Citizen of What Country? 21206 tuenue Funeral 5701 Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No II Fes, Give Year or Detection Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Newer Married 2 ☐ Married Specify: Black 1 Yes 2 No Maryland 21215-0036 þ 3 ₩idowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. PERVISOR 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be BARNER HATTIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Enobia BARNER Department of Health a Important; If item 27 is any injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee RATA respiratory arrest, BROADWAY Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac or 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final ASCVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗌 No 25 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 1 X Yes 2 ☐ No Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? I or Attending F after death. 5 Pending investigation Injury 1 🗷 Natural 1 No 2 No 2 Accident 6 Could not be determined 28e. Place of injury At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral E Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number M.D APRIL 24,2012 D0070999

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IDD O 7 2010

Jewn J. fare

ORIGINAL

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death
2.23 PM 2. Date of Death Physician/ 10 bes 2 Da AMONTH Medical give street and number, **Examiner** 4a. Facility Name (if not institution) 4b. City, Town, or Location of Death 4c. County of Death Medica in 8. Date of Birth (Month, Day, Year, **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Director 6 Mary 28a-f show 10c. City, Town or Location Director other traumatic event, the Medical Examiner must be notified 1 Yes 2 No 20 De. Street and Number 10g. Citizen of What Country Completed by Funeral 23a 1. Marital Status 12 Mac De 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas Mexican, Puerto Rican, etc.) 14. Race - American Indian. orces? 1 Never Married 2 Married Black White etc. õ Yes s, Giv 2 No Maryland 21215-0036 "natural", 1 Yes 2 No Specify 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than /Secondary (0-12) College (1-4 or 5+) Mecha Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Blackwell Sr. ame/Relationship (Type, Print) and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Stree Department of Health a Important: If item 27 is any injury or other tran treeman Ave Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other Gerrison 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses mald a E 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause or Interval Between Onset and Death Immediate Cause (Final Physician/ etastat disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical P.O. Box 68760 the Phy as ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Month Pregnant at time of death Day Year Yes 2 No signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 🗡 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No After this certificate 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2, Z No Other: မ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director; A Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completely (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of feath (Item 23a) (Type, Print) Va rez, Mi althrone VA 20

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ Victor Joseph Balsarick, Jr. APril 26 Medical 5:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Health & Rehab Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 218-36-5072 **Director** 1 M 2 □ E 70 July 14, 1941 Maryland 28a-f show Ħ 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Orchard Beach 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 719 Hilltop Road 21226 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗷 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 N/A Truck Driver B. Green Trucking Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F မ Victor Joseph Balsarick, Sr. Stella Unknown 1 and 2 should be if Health and Men 19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 719 Hilltop Road Orchard Beach, Maryland 21226 Paulette G. Richter-Representative 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Atlantic Cremation 04/27/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 MOO-732 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Aortic Stenosis Medical Due to (or as a consequence of) Examiner Pulmonary Hypertension Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed Hypertension and burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Cardiomyopathy Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Kidney Disease 24a. Was an autopsy page certificate Hyperlipidemia 1 ☐ Yes 2 ☐ No 2 X No Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending iniury death. Accident 1 Yes 2 No the ' Investigation s after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, To the Hospital 24 hours Funeral Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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☐ Medical Examiner: On the basis of examination and of the cause (s) and t 29a Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 29b. Signature and life of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

3233 Superior Lane, Bowie, Maryland 20715
Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanu

APR 2 7 2012

D58580

April 27, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Myrtle Ennettee Burge Medical \cap 201 10:10p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 518 Lyndhurst Street Baltimore 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Davs Hours Country) 214-40-5507 Director 1 □ M 2 🔏 F 27 95 12 16 MS 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1X☐ Yes 2 ☐ No MD NA Baltimore 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 518 Lyndhurst Street 21229 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 □ Divorced Specify: Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Dept. of Recreation and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the grade 4vrs Director and Parks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron Anthony Barnes Cynthia King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shart of Health au Cherryale Burge-Daughter 518 Lyndhurst Street, Baltimore, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 4 X Donation 5 Other (Specify) SVC-UNIV 4/24/2012 Bethesda, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Po Month Day Pregnant at time of death 5 Other (specify) Year Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate | 1 ☐ Yes 2 ☐ No Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical l a 26. Place of Death (Check only one) Hospital 2 No 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 4 Nursing Home this funeral s after death.
I Director: After the order of the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 24/12 37111

Registrar

DHMH 17 Rev 06-2011

State

4600 put an & High way

MD2122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's

ULCPATEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar			d / Depa		Health a	and Mental Hy	giene Reg. No. 201	
П	Physicia	ın/	1. Decedent's Name (First, Middle, Michael	Last) Philip		Bo	perner		2. Date of De Month April	Day 2012	3. Time of Death
н	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, o	or Location of		4c. County of De	
أمميده	F		6004 Welborn I				Ве	thesda			gomery
	Funeral Director		5. Social Security Number 579-46-9760	6. Sex 1 X M 2 □ F	ge (In yrs. Ia 76	ast birthday) Yrs.	If Under 1 Year Months Days	Hours 1	Min. 8. Date of Bir (Month, Date of Aug • 2	th 9. E 2, 1935 Pe	Sirthplace (State or Foreign Country) ennsvlvania
	d d	_	Usual Residence of Decedent 10a. State 10b. County		I 100 City	y, Town or Lo	ection		11105 2	2, 1939 1	10d. Inside City Limits
	/arylan 8a-f sh tified a	Director		gomery	100.00		Betheso	la			1 X Yes 2 □ No
	th the Na or 2		10e. Street and Number				10f. Zip Code	00016		10g. Citizen of What (
	eath wi	Funeral	6004 Welborn I	12. Was Decedent		S. 13. V	Was Decedent of H	20816	in? (Specify Yes or No- Puerto Rican, etc.)	United S	
21215-0036	rs after de iral", or if Examine	þ	1 Never Married 2 X Marri 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates.		1	f Yes, specify Cub I ☐ Yes 2 🏹 No		Puerto Rican, etc.)	Black, Wh	
15-0	72 hou n "natu fedica	Completed	15. Deceden (Specify only highes			(Give I	dent's Usual Occup kind of work done O NOT use retired	during most	of working	16b. Kind of Busines	,
212	within rgiene. ner tha t, the N		Elementary/Seconday (0-12)	College (1-4 or 5	5+)	l	ign Serv:	,	ficer	1	onal Affairs
Maryland	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Le Alfred	Victor	1	Boerne	r	1	r's Name (First, Middle, anor	′ _	eming
Man	and 2 shoul Health and I tem 27 is ma ther traums		19a. Informant's Name/Relationsh Dorothy P. Boer						or Rural Route Number Bethesda,	er, City or Town, State, 2 MD 20816	Zip Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)			emetery, cren	sition (Name of natory or other pla	ce)	Date 04/26/2012	20c. Location - City of Beltsvi	or Town, State
Balti	permit. I Departn Importa any inju once.	1 10	21. Signature of Fune al Service Li	censee					d Crematio Silver Spr		20910
ı			23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final	nly one cause on each lir	ie.	n. Do not ente					Approximate Interval Between Onset and Death
-	Pnysician/ Medical		disease or condition resulting in death)	a. Due to (or as	a consequ						1 YEAR
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequ	ience of):					
DO	s be executed ysician and e burial-transit	Examin	cause. Enter Underlying Cause (Disease or irrighty that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):					1
09	tte be ex hysiciar he buria	cal	•	d							
68760	ertifica iding pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy				20d D-tf-	
. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 4 Pregnant : 9 Unknown			Ectopic pregnan Other (specify)	су		23d. Date of c	Day Year
s, P.O.	es that the signed by the signed by the details	d by PI	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying cause g	iven in Part I.	2001 014 1	obacco use contribute	to the cause of death?
ord	v requi	olete							24a. Was	an 24b. Were a	utopsy findings available
Rec	The larate ha	Com							auto perfo 1 \square	ormed? death?	es 2 No
ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 【▼ No	Hospital:			Oth	or-	(Check only one)		
n of V	ding Phy h. After this funeral d	ate: To	27. Manner of Death 1XXNatural 5 Pending	28a. Date of inju (Month, Da	ury	ER/Outpatien 28b. Time of injury	28c. Inju	ry at	28d. Describe I	dence 6 Other (Spenow injury occurred	ecify)
Division of Vital Records,	or Atten after deat Director: in by the	Certificate:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determin	ot be			eet, factory, office	1163 2		Street and Number or Fi vn, State)	ural Route Number,
	Hospital 24 hours Funeral eted filled	Medical	(Check 2 L Medical Ex	Physician: To the best of caminer: On the basis of caminer: To the basis of the bas	examination	and/or invest	igation, in my opini	on, death occ	curred at the time, date a	and place, and due to the	e cause(s) and manner stated.
_	To the vithin To the comp.	2	29b. Signature and title of pertifier	Tacuquer. To the	Jost Of HIS	in owieuge, c	29c. Licens	e number		29d. Date signed (Mor.	th, Day, Year)
	0,		30. Name and address of person w	who completed course = 5	teath (lies)	220) /5: 5		D23600		APRIL 2	J, ZUIZ
	10		BRUCE R. KRESS				ET, NW.	#1125 ,	WASHINGTO	N D.C. 20	0037
	Stat Registra	e	31. Date filed (Month; Day, Year) APR 27		ar's Signat	de fa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 24, 2012 11:43 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 917 Oakdene Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/04/1914 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 215-14-4444 Director 97 1 M 2 XF Maryland Usual Residence of Dece 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Baltimore Middle River 1 ☐ Yes 2X No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 917 Oakdene Road 21220 U.S.A. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian. Armed Force 1 ☐ Yes 2**X** No If Yes, Give Black White etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. "natural", 3 X Widowed 4 Divorced Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. 8 Owner/Operator other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Frank Kowalski Victoria Razmuss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Theresa Bohns (Daughter) 917 Oakdene Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State Sacred Heart of Mary 04/28/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility. Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Imme date Cause (Final Prominian/ dise se or condition sulting in death) Medical Due to (or as a consequence of) Examiner EHEART PAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to lot as -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ į in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed' Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes မ 4 Nursing Home 5 Residence 6 Other (Specify this 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4

Homicide determined Medical

Registrar

29a. Certifier

(Check

only one)

Dr. Meeta

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Gulati,

1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

9649 Bel Air Road, Baltimore, Maryland 21234

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month :40 P Phen Ame Medical Facility Name (if not institution, give street and number, City, Town, or Location of Death **Examiner** 4b 4c. County of Death d.CA Himore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Min. 43 Director 577-80-5298 1 🕅 M 2 🗆 F 09/25/1968 Wash D.C. Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 🗌 Yes 2 🌠 No MD Germantown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or Funeral 11900 Rathbone Court 20874 USA items? filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or ite Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1987 – 90 1 Yes 2 XNo Specify. White Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Caterer Food Business 2yrs permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Bramell Sharon Van Zytveld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11900 Rathbone Court Germantown MD 20874 Sharon Bramell Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other p.
Atlantic Crem 1
Burial 2
Cremation 3
Removal from State 04/20/12 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Euneral Service Lice Thomas Allen P.A. 7090 Ridge Rd HanoverMD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. i i n Siabetic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying iner Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trar attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death be detached the Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 death? hours after death. Ineral Director; After this certificate Yes 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier **Tpletely** only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 10 North GREENESTREET Baltimore

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Physician/ April Maggie Burke 22, 10:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Mandeville House Waldorf If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🖾 F Months (Month Day, 79 1932 Director 424-28-5851 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No Mobile ALMobile ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral USA 859 Chin Street 36610 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify. If Yes, Give Specify Completed 3 XWidowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tailor Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked of r other traumatic ever ပ Sherman Morrissette Mary E. Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Timmony Circle, Accokeek, MD James P. Burke - Son Baltimore, it of Hea : **If item** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Byrial 2 🗐 Cremation 3 🗆 Re ò Department of Important: If any injury or 4/28/2012 4 🗌 ponation Other (Specify Plateau Cemetery Mobile, Alabama 22. Name and Address of Facility Metropolitan Funeral Service Signature of Funeral Service Lic 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cancer of Lung disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? signed by the atte Day Pregnant at time of death 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 K Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After th 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of perso who completed ca e of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registra		S	tate of	Maryla		artmer			and N	nental Hy	0	2012	2 13188
	Dharisis	/		Name (First, Mid	dle, Last)				, imout		Joann		2. Date of De	ath		3. Time of Death
	Physicia Medic			ORENC				SER					Month	1 9	2012	(0:05AM
	Examin	er		me (if not instituti			per)				Location of	of Death			ounty of Death	
	Funeral		5. Social Secu	Courts	of Pot		7. Age (In yrs	. last birthday,		omac r 1 Year	If Under	24 Hrs.	8. Date of Bir		lontgom	ery place (State or Foreign
	Director		322-1	4-3626	1 □ M		98	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	Cour	ntry)
	ld now	Ļ	Usual Reside	ence of Decedent			100.0	City, Town or L	ocation				1-6-191	. 4		inois 10d. Inside City Limits
	larylar 3a-fsl ified	Director	MD		tgomery	V		otomac								1 X Yes 2 □ No
	the N or 28		10e. Street and			<u> </u>			10f. Zip	Code			T	10g. Citize	n of What Cou	ntry?
	h with ns 23a nust I	Funeral	8209	Buckspa					20	854				Unit	ed Sta	tes
	r deat or iten niner r	by Fu	11. Marital Sta	itus Married 2 🗆 M	. A	Vas Deced Armed Ford Yes		J.S. 13	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14	. Race - Americ Black, White,	
21215-0036	rs afte ural", (Exan	ed b		wed 4 X Divorc	1	f Yes, Give ear or Dat			1 🗌 Yes	2 💢 No	Specify:			Sp	ecify:	White
5-0	"natu "natu edical	Completed		15. Dece (Specify only hig	dent's Educati thest grade co			(Give	edent's Usu e kind of wo	rk done d		t of work	ing	16b. Kind	of Business/In	dustry
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þ	illed w	Be	17. Father's N	ame (First, Middle				Teac	Mer				e (First, Middle,	Maiden Sui		
ylaı	ild be Menta narked	은	David	d Greenb	erg						Minr	nie E	Esther 1	Levin		
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	i	Ĭ.	t's Name/Relatio		rint)		1.	_	•			I Pote		,	nd 20854
ē,	f Heali f Heali item 2 other		20a. Method c					. Place of Disp	osition (Nar	ne of	- :		Date		tion - City or T	
mo	Page nent o ant: If Iry or			al 2 \square Cremation 5 \square Othe		oval from S		cemetery, cri idean N	-			4-23	3-2012		, Mary	
Baltimore,	ermit. epartn nporta ny inju	1	21. Signature	of Euro	Lighty Se		Blake							_		Direction
Ш	90 2 2 3			1	72	-	MO114								, Maryl	and 20852
	AND DESCRIPTION OF THE PARTY OF		shock, o	inter the disease, or heart failure. Lis	or complication only one cal	use on eac	h line.			e or ayını	g, such as	cardiac d	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical		disease or co resulting in de	ndition	a		heime:	r's Dis	sease						-	
	Examiner	<u>.</u>	Sequentially 1	ist conditions,	b. —											
	ed nsit	Examiner	cause. Enter Cause (Disea	to immediate Underlying	₹	Due to (c	r as a conse	quanca of,:								
	te be executed nysician and he burial-transit	Exa	that initiated resulting in de	events	c	Due to (o	r as a conse	quence of):								
90	te be e	dical			d											
Box 6876	eath certificate attending phy d for use as the	/Me	IF FEMALE:		230 1	f ves oute	ome of preg	nancy							1	
X	attend attend	ician	in the pas	edent pregnant st 12 months? 2 No	1	Live B	irth 2 🗌 Fe ant at time o	etal death 3	☐ Ectopic ☐ Other (s)		ÿ			23	d. Date of delive Month	rery Day Year
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, P.O.	requires that the de: been signed by the s should be detached	ξ	Part II. Other:	significant cond	itions contribi	uting to de	ath but not r	esultin g in the	underlying	cause giv	en in Part	I.				he cause of death?
rds	require seen s should	eted														bably 4 Unknown
eco	The law ate has be page 2 s	Completed								_				psy ormed?	prior to co death?	psy findings available empletion of cause of
E B	ilcian: The certificate rector, pag	Be Co		referred to medic	al					26. Pla	ace of Dea	th (Checi	1 Yes	2 No	1 Yes	2 L No
Zį:	hysici nis cer Il direc	10 B	examiner? 1 \(\sum \) Yes		Hospi		npatient 2	☐ ER/Outpati	ent 3 🗆 D	Othe	er: 4 🛛 No	ursing Ho	me 5 Resi	dence 6	Other (Specify	v)
Division of Vital Records,	Attending Physician: or death. ector; After this certific by the funeral director,	ate:	27. Manner of 1 Natur	ral 5 🗌 Pen	ding	8a. Date o (Month	f injury , Day, Year)	28b. Time injury		8c. Injury work	?	- 1	28d. Describe I	now injury o	ccurred	
Sion	affer datending affer death. Director: Affer dir by the fune	Certificate:	2 Accid	de 6 🗆 Cou	stigation ld not be rmined	8e. Place o	of Injury - At	home, farm, s	M treet, factor		Yes 2	-	28f. Location (Street and N	lumber or Rura	I Route Number,
DIV	s affer al Directory		4 🗆 🗝	icide dete	minea	buildin	g, etc. (Spec	ify)		,		ļ	City or Tov			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director; After this certificate has been signed by the attending physician and completely filled ir by the funeral director, page 2 should be detached for use as the burial-transicompletely filled in by the funeral director, page 2 should be detached for use as the burial-transicompletely filled in the funeral director, page 2 should be detached for use as the burial-transicompletely filled in the funeral director, page 2 should be detached for use as the burial-transicompletely filled in the funeral director.	Medical	29a. Certifier (Check	2 L Medica	I Examiner: (on the basis	s of examinat	ion and/or inve	estigation, in	my opinic	on, death or	ccurred at	nd due to the cathe time, date a	and place, ar	nd due to the ca	use(s) and manner stated.
	To the within 2 To the comple	Σ	only one 29b. Signature	e and title of Certif		cinoner:	to the pest 0	THY KNOWIECC		urred at t		ile and pla	ace, and due to		and manner as signed (Month,	
				Uble	es V	Y				80	0525			4-20	-2012	
(10		1	address of person						7e. 7	#100.	Roc	kville.	Marv	land 20)850
	Sta			Month, Day, Year)											
	Registra	state 31. Date filed (Month, Day, Year) 33 Registrar's Signatus APR 2 7 2012 Common Strar 2 2012														

2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Hospital or Attending Physician: c Funeral

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) ORIGINAL

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

April 24, 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan	-	rtment of F tificate of D	Health and M Death		20	112	13190
			Registrar 1. Decedent's Name (First, M	liddle, Last)		007	incate or z	Jodan	2 Date of Deat	eg. No. /		. Time of Death
15	Physicia Medic		Richard Ear		Jr.				Month	14 Pay 2	012 j	1:00 AM M
	Examin	er	4a. Facility Name (if not institu				- //	Location of Death		4c. County	of Death egany	
بمجنسة	Funeral		Western Mary 5. Social Security Number		Age (In yrs. la	ıst birthday)	Cumber If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace	e (State or Foreign
	Director		200-32-3090	1 🔀 M 2 🗆 F	69	Yrs.	Months Days	Hours Min.	(Month, Day, 10/01/		Penns	ylvania
	nd how at	o.	Usual Residence of Decede 10a. State 10b. Co			, Town or Loc	ation		10/01/	1712		Inside City Limits
	Maryla 18a-f 1	Director	WV Min	neral	N∈	ew Cree	k					1 🛭 Yes 2 🗆 No
	h the last or 2 be no		10e. Street and Number				10f. Zip Code			I0g. Citizen of V		
	ath wit	Funeral	HC 72 Box 890	C 12. Was Decede	nt Ever in LLS	13 V	26743	spanic Origin? (Spe	cify Yes or No-	U.S.	A . e - American II	ndian
စ္	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 🕱	Married Armed Force	s?	If	Yes, specify Cuba	n, Mexican, Puerto		Blac	k, White, etc.	Talan,
21215-0036	tural" al Exa	ted	3 Widowed 4 Divo	Tear of Date:	S.		Yes 2 X No			Specify:	wnit	
15	72 hc in "na Medic	Completed	(Specify only i	cedent's Education highest grade completed)		(Give k	ent's Usual Occup ind of work done o NOT use retired)	ation furing most of worki	ng	16b. Kind of B	usine <i>s</i> s/Indust	ry
212	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Elementary/Secondary (0- 12	-12) College (1-4	or 5+)	Sur	ervisor			Indust	rial S	olutions
Maryland		To Be	17. Father's Name (First, Mide	. ,	Cvs			18. Mother's Name Betty	e (First, Middle, M Car		9)	
ير	2 should be file th and Mental 27 is marked o traumatic eve	Ė	Richard Ea 19a. Informant's Name/Relat		Sr.	19b. Mailin	a Address (Street a	and Number or Rura			tate, Zip Code)
	~ ~ ~ =		Catherine Bi	ckel / Wife				C, New Cre				
altimore,	- 4		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema	ation 3 🗆 Removal from St		lace of Dispos emetery, crem	sition (Name of atory or other plac	:e)		20c. Location -	-	
<u>=</u>	Page and and uny		4 X Donation 5 Oth	· · //	An		ifts Regist	4	7/2012 Anatomy	Hanover		
Ba	permit. Departs Import any inj	- 1	21. Signature 1 uner 1 er	Vice 170 risee		- 1		elley Dr.,				
	Physician/ Medical sician and physician and	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a conseque as a conseque as a conseque	ence of):	SHOC DNIA,	COMM	UNITY	BOOL	ZI MED:	2017
). Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	1 Live Bir	th 2 🗌 Feta nt at time of c	l death 3	Ectopic pregnand Other (specify)	sy			te of delivery nth Day	/ Year
P.O.	s that gned be det		Part II. Other significant con			-	_	ven in Part I. Y <i>ANOIN</i>		pacco use cont		
rds	require	eted	(ONGET	The Mapo	/		RE, AC		24a. Was a			y 4 Unknown findings available
Records,	sician: The law certificate has b lirector, page 2 s	Completed by	CTENING	6/4/14	IFA	MIRE	MANI	11(11)	autops perfor	med?		etion of cause of
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Division of Vital	l or Attend after death Director: /	Certificate:	3 Suicide 6 C	ould not be 28e. Place of	Injury - At ho etc. (Specify		et, factory, office		28f. Location (St City or Town		er or Rural Ro	ute Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 Medi	ifying Physician: To the besical Examiner: On the basis ifying Nurse Practitioner: To	of examinatior	n and/or invest	igation, in my opinio	on, death occurred at	the time, date ar	d place, and du	e to the cause(:	s) and manner stated.
_	To the within 2 To the complete		29b Signature and title of ce		1		29c bicense	3769		9d. Date signe		
			Jan 11	,,,~	-/		1018			1/2	1110	
			/	rson who completed cause of M.D., 12500				umberland	, MD 215	502		
	Sta	e	31. Date filed (Month, Day, W	ar) 32. Reg	istrar's Signat							
	Registr	ar	ADDO	7 2012		1 0	-					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Physician/ 25 A M Quentin Bates April 6:12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 7. Age (In yrs. last birthday) Year If Under 24 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 482-16-4681 Director 1 XM 2 □ F Usual Residence of Decedent 93 March 28, 1919 Iowa 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 8215 Lilly Stone Drive 20817 United States ed other than "natural", or items event, the Medical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify Completed Year or Dates. WWIT White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Foreign Service Officer Federal Government Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Vernon Welker Bates Gail Schillerstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Madelyn Dougherty Bates/Wife 8215 Lilly Stone Drive, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery May 1, 2012 Washington, D.C. . Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 th Fin M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician. Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Urinary Tract Infection Sequentially list conditions, if ally, leading to immediate cause. Enter Underlying Examine bue to for as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be attending plant of the season IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 Yes 2 L 9 Unknown Yes 2 No be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Hemorrhagic Shock Secondary to Ureteral Trauma Records, Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes or Attending Physician: director, Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNa မှ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 XNatural Division Accident
Suicide Investigation M 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one 29b. Signature and tite of certific 29c. License number 29d. Date signed (Month, Day, Year) D72726 April 25, 2012 ss of person who completed cause of death (Item 23a) (Type, Print) Pihl, M.D.8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) APR 2 7 2012 32. Regist r's Signature State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health				12	13192
_		State Registrar Certificate of Death Decedent's Name (First, Middle, Last)		Date of Dear	Reg. No. 20	112	13174
Physicia		GERARD THOMAS BOWEN			Day 2012	Year	3. Time of Death 10:42 A. ^M
Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locatio		MIKIL A	4c. County	of Death	10:42 A.
		1203 RAVEN WOOD APT.303 BELCAMP				HARFO	ORD
Funeral Director		5. Social Security Number 215-78-1798 Usual Residence of Decedent 6. Sex 1 🔀 M 2 🗆 F 7. Age (In yrs. last birthday) 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) 1 🛣 M 2 🗆 F 9 Yrs.	rs Min.	Date of Birth (Month, Day, -10-19	Year)	9. Birthpla Country MARY	
and show	اة ا	10a. State 10b. County 10c. City, Town or Location				100	d. Inside City Limits
Maryla 28a-f	rect	MD. HARFORD BELCAMP					1 🗌 Yes 2 🗶 No
with the s 23a or 2	Funeral Director	10e. Street and Number 10f. Zip Code 1203 RAVEN WOOD COURT APT.303 2101	17		10g. Citizen of V USA		y?
Ind 21215-0036 I filed within 72 hours after death with the Maryland Ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces 1 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 14. Was Decedent Sever in U.S. Armed Forces 1 15. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 16. Yes 2 No Specify Cuban, Mexic 1 17. Yes 2 No Specify Cuban, Mexic 1 18. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 19. Was Decedent Ever in U.S. Armed Forces 2 19. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 19. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 19. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 19. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 19. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 19. Was Decedent of Hispanic C If Yes, Specify C If Yes, Specify C If Yes, Specify C		Yes or No- an, etc.)	Blac	e - Americar k, White, et	C.
5-00; 2 hours a "natural sidical Ex	Completed	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during me			16b. Kind of Bu	WHIT!	
2121 within 73 rgiene. ner than t, the Me		Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired) POLICE OFFICE			LAW ENF	ORCEMI	ENT
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygtene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To Be		lother's Name <i>(Fii</i> ERALDINI			2)	
re, Maryla t and 2 should be f Health and Men item 27 is marke other traumatic	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num			-		de)
		WILLIAM BOWEN BROTHER 4 MALLOW COURT 20a. Method of Disposition 20b. Place of Disposition (Name of		-	MD. 21		n Ctata
		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date		20c. Location -		
Baltimo permit. Page Department o Important: If any injury or		4 Donation 5 Other (Specify) HIGHVIEW MEMORIAL 21. Signature of Funeral Service License 22. Name and Address of Fac	4-26-20		<u>FALLSTO</u> FUNERAL		
	1	610 W. MACPHA			L_AIR,M		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or res	spiratory arre	est,	1	Approximate nterval Between Onset and Death
Physician/ Medical	6 1	Immediate Cause (Final disease or condition resulting in death) Sezore Due to (or as a consequence of):					Driset and Deam
Examiner						- 1	10 years
n ti	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
'60 ate be executed bhysician and the burial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
be ex sician buria	dical						
3760 ficate b g physia as the k	/ledi	_ u.		1			
. Box 68760 e death certificate be executed the attending physician and ched for use as the burial-transi	Physician/Me	IF FEMALE:	~	A	23d, Dai Mo	te of delivery	
ords, P.O. Box requires that the death. been signed by the atte should be detached for	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	_			cause of death?
Ision of Vital Records, Attending Physician: The law requires or death. ector. After this certificate has been sign by the funeral director, page 2 should by	Completed			24a. Was a		Were autops	y findings available
ital Reccidician: The law certificate has rector, page 2	Som			autops perform	med?	orior to comp death? 	pletion of cause of
Vital nysician: ils certifica	Be (examiner?	Death (Check onl				
f Vital Physician: this certific ral director,	은	1 Inpatient 2 ER/Outpatient 3 DOA DOA 4	Nursing Home				
In of V Iding Phys th. After this funeral d	cate	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28c. Time of 28c. Time of 28c. Injury at 28c. Time of 28c. Injury at 28c. Time of		Describe ho	w injury occurre	ed	
Division of Hospital or Attending Pt 24 hours after death. Funeral Director. After the tely filled in by the funera	Certificate:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (St City or Town	reet and Numbe n, State)	er or Rural R	oute Number,
To the Hospital or within 24 hours afte To the Funeral Direct completely filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date are (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are control of the post of my knowledge, death occurred at the time, date are considered in the control of the post of my knowledge, death occurred at the time, date are control of the post of my knowledge, death occurred at the time, date are control of the post of my knowledge, death occurred at the time, date are control of the post of my knowledge.	h occurred at the	time, date an	d place, and due	to the cause	e(s) and manner stated.
To the comp	2	29b. Signature and title of certifier 29c. License number	er		9d. Date signed		
		Stronde MD D3812	25		4/2	14/20	4-4
37		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Pondek ms 103 Bry Blud	Belo	40	Md.	210	17
Sta Registr		31. Date filed (Month Por, Year) 2012 32 Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Physician/ Month April Oakie Herman Bishop III 7:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 731 Darlington Road Darlington Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 28, 1962 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** Days 1 1 M M 2 □ F Months Hours 214-90-0124 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Harford Darlington 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 731 Darlington Road 21034 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give "natural", or 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Manager Moving and Storage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oakie Herman Bishop Jr. Eunice Ellen Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 Faith A. Bishop / Wife 731 Darlington Road, Darlington, MD 21034 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite Page 1 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs., LLC 4-30-12 Bel Air, Maryland 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 21. Signature of Funeral Service Lifeinste any mas Part 1. En ir the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Caus III inal Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a con guence of) death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the inding pure IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 L 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ sign. be (Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work hours after death, ineral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation by the f 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts or examination and/or investigation, in my opinion, usage values and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title. H0055026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rowlandsville Conovingo MD 21918 Nay Steven OF

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 25, Day 2012 Year Physician/ 5:30 P M Dona Christine Belue Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill 805 Gail Court If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 □ M 2 🛣 F Months Days Hours Alabama 418-30-7721 90 Nov. 1921 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes 2 No Maryland | Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 Gail Court 21050 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify. 3 ₩ Widowed 4 □ Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert (nmn) Camp Elna (nmn) Snoddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Regina Pasquale / Daughter 805 Gail Court, Forest Hill, Maryland 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Rem val fr 4 Donation 5 Dpher (Specify) 4-28-2012 Anderson, Alabama Mitchell Cemetery t re of Funeral 21. Sign 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe shock, or heart failure. List only one cause on each line.
ediate Cause (Final ase or condition Immediate Cause (Final Onset and Death Physician/ Week disease or condition Medical resulting in death) Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exew within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician at completed filled in by the funeral director, page 2 should be detached for use as the burial-t Physician/Medical Records, P.O. Box 68760 < IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kidney 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 No Hospital: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, 035012 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MD 21014 500 Upper Chesapeake Dr. 32. Registraris Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Trina Alice Berry 1) OR am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death n/a 701 North Augusta Avenue Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral Director** 212-96-0575 1 🗆 M 2 🔀 F 09/01/1977 Maryland 34 Yrs show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD n/a 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 21229 USA 701 North Augusta Avenue items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or δ Yes Maryland 21215-0036 If Yes, Give X Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Environmental Engineer Marley Station of Health and Mental Hygi item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Adeline Barnes Anthony Donald Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 N. Augusta Ave Baltimore, MD 21229 Orpah Berry/ Sister Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or once. ò 4.24.2012 Baltimore, MD On-Site Crematory Signature of Funeral Se John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): -transit and that initiated events resulting in death) Last Due to (or as a consequence of): burialng physician as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months?
1 __,Yes 2 __ No Month Pregnant at time of death 5 Other (specify) Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed, 2 No Yes 2 N 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 21/10 Other: မှ 1 Ves 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5N Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State

DHMH 17 Rev 06-2011

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Marvin Buckson, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 13196 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner Marvin Lee Buckson Jr. 2343 hrs April 17, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death n/a Baltimore Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 6. Sex **Funeral** Months Days Hours Director Country) MD 1X M 2 F 29 09/07/1982 217-02-3773 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 Yes 2 No n/a Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
sent If item 27 is marked other than "natural", or items 23a or 28a-f sho antir fraumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 317 East North Avenue Apartment 217 21202 USA Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Armed Forces? Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: Black ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 unemployed n/a 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Marvin Lee Buckson Roberta Outlaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Outlaw / Mother 317 E. North Ave Apt #217 Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State mt. Carmel Cemetery 4.28.2012 Baltimore, MD 4 \ Donation 5 Other Specify of Funeral Se vio ²² Name and Address of Facility
John L. Williams Funeral Directors, P.A. 4517 Park Heights Avenue Baltimore, MD J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ilure. List only one cause on each line. Between Onset and /Medical a. Gunshot Wounds of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ć 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has I funeral director, page 2 ch performed? death? Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 1 V Yes No 28a. Date of Injury (Month, Day Year) Apr 17, 2012 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot 2309 hrs thours after death.

'uneral Director: tell filled in by the fi Natural 1 Yes 2 V No 5 Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State)
1800 Block of N. Spring Street, Baltimore, MD To the Hospital within 24 hours at To the Funeral I completely filled determined (Specify) Local Street 4 / Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical . 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 18, 2012 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Yea Registrar's Signa State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

	1 State Registrar	- Contact Addition	t A)		Cer	tificate	e of E	Death		2. Date of D	Reg. N	o. 2	0	2	,	31:
an		^{me (First, Middle,} Jerome Br	,							Month		ay 7	Year		3. Time o	OP M
cal ner			give street and number)		-			Location of	of Death		40	c. Count		ath		
			lin Street				alti					n/a				
	5. Social Security 248–98-		5. Sex 7. Ag 1 → M 2 □ F	ge <i>(In yrs.</i> 1 61	last birthday) Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 12/07)	irth ay, Year	r)	1 0	Countr	ce (State o	_
	Usual Residence		Λ	01			<u> </u>			12/0//	1195	0	50	uuı	Carc)1116
	10a. State	10b. County		10c. City	y, Town or Lo	cation								10d	. Inside C	•
Director	MD	n/	'a		Bal	timor	e								1 XYes	2 No
	10e. Street and N		klin Street	10f. Zip Code 21229							10g. Citizen of What Co			Country	?	
Funeral	11. Marital Status		12. Was Decedent	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify)									ice - Am	nerican	Indian.	
		rried 2□ Married	Armed Forces	?		_	_		i, Puèrto	Rican, etc.)			ack, Wh			
i by	3 ☐ Widowed	4 Divorced	Year or Dates:			1 ∐ Yes 2	² X No	Specify:				Speci	ify:Af:	ric	an-Ar	meri
etec	(Sp	15. Decedent's ecify only highest	Education grade completed)		16a. Deced (Give	lent's Usua kind of wor	al Occupa rk done d	ation <i>Juring mos</i>	t of worki	ing	1	Kind of E			stry	
Completed	Elementary/Se	condary (0-12)	College (1-4or	(Give kind of work done during most of working life. DO NOT use retired) Roofer							Wai	rren ofin	Ehi a Ca	ret	any	
		e (First, Middle, La	last)	18. Mother's Name (First, Middle												
To Be	Hanky 1	Brown						Victo	oria	Joye						
	19a. Informant's	Name/Relationship	(Type. Print)							al Route Numi						
		Rouse-Ne	ephew	T				n Rd		t C Bal	_					
	20a. Method of D 1 ☐ Burial		3 □Removal from State	. 0	Place of Dispo	natory or o	ther place			Date		Location	-			
	4 Donation	n 15 ☐ Other (Spe	ecify)	On-	Site C			-		.2012		ltim		•		
	21. Signature at	Funeral Service	Cerroee	\mathbf{z}	Jő	hn L.	Wil	liams	š Fur	neral [oire	ctor	s, I	P.A	•	
^ '	23a. Parri. Enle	r the disease, or co	omplications that cause	d the death	h. Do not ent	er the mode	le of dying	leighi g, such as	cardiac o	ve Balt	LIMOI arrest,	re,_	MD 2	A	pproxima	te
	Immediate Caus	eartiallure. Listoi e (Final	nly one cause on each l	ine.										1 1	iterval Be	ween
			11/2/11/	7+7	001	ALLA	0 1	- 0	ron)m	17		Ö	nset and	Death
	disease or condi resulting in deat	tion n)	a. Due to (or as	a consequ	uence of):	lul	av	- (av	anc)m	a		Ö	nset and	Death
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xaminer	resulting in deat	conditions, immediate derlying or injury nts	b	s a consequ	uence of):	lul	av	- (OV.)m	a		Č	nset and	Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 7743 Notley Road Pasadena Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 219-10-6624 1 🗆 M 2 🔀 F Maryland May 29,1922 Yrs 89 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 7743 Notley Road U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Miller Barbara John Huppman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33A Swan Street Aberdeen, Maryland 21001 Carolyn C. Thomas (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/27/2012 Glen Burnie, Maryland Atlantic Cremation McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses MOO-732 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ EMENTA EMIS Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE es, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the air Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed cate has by page 2 s To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D003658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

ERSH

32. Registrar's Signatur

2

31. Date filed (Month, Day, Year)

APR 2 7 2012

12-03161 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Carolyn Carrington 2012 13199 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1914 hrs April 23, 2012 **Medical Examiner** Carrington Carolyn 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2726 N. Longwood Avenue 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Director 219-52-8409 1 M 2 X F Country) MD 63 19 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show Baltimore "natural", or items 23a or 28a-f sho Examiner must be uotified at once, NA **altimore, MD 21215-0036**rmit. Pages I and 2 should be filed within 72 hours after death with the Maryland epartment of Health and Mental Hygiene.

portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be modified at the contract of the contract of the medical Examiner must be modified at the contract. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 2726 Longwood Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes Black 4 Divorced if Yes, Give Year or Dates: 3 Widowed 1 Yes 2 X No specify: Specify: ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Teacher 4yrs 12th grade Public Schools 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lillie Mae Owens Be John H. Carrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2726 Longwood Street, Baltimore, Md 21216 Lillie Mae Carrington-Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4/28/2012 Woodlawn, Md Park Memorial King 4 A Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Eacility
March F/H West 4300 Wabash Ave, Baltimore, 21215 Approximate Interval disease, or complications bat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Cal AMENDED UNPENDED Physician/Medi Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) j Yes 2 V No 9 Unknown Unknown the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed by <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown should be Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 s performed Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other: Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes No 28a. Date of Injury (Month, Day, Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 24, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D.

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar 31. Date filed (Month, Day, Year APR 2 7

ORIGINAL

32. Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	1- For State	ite of Maryland	•	artment of <i>rtificate of</i>		d Menta	al Hygiene	Reg. No.	201	2	3201	
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle Kelly Lynn C					***	2. Date of D Month April 24	eath Day	Year	3. Time 1732		
predical Examiner	4a. Facility Name (if not institution		er)	4	b. City, Town, or	Location of		4c.	County of Dea	th		
Funeral	109 Oella Avenue 5. Social Security Number	6. Sex 7	Age (In yrs. la	ast birthday)	Catonsville If Under 1 Yea	r If Under	24Hrs. 8. Date of		altimore Co		tate or	
Director	047 44 5700	1 M 2 F	41	Yrs.	Months Day	s Hours	Min. 06/	22/1	970 Fore	ign ountry)	MD	
ıny	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on	-		10d. Inside City Limits				
Maryland 28a-f show any d at once. ector	MD Balti	more		atonsv						1 Yes 2 X		
th the Maryland 23a or 28a-f sho notffied at once.	10e. Street and Number 109 Oella Av	enuo			10f. Zip Code	228		10g. Citizen of Wh				
with the sa case of t	11. Marital Status	12. Was Decede			Decedent of Hi	spanic Origir	n? (Specify Yes or	No-	14. Race - Ame	rican India	n, Black,	
er death with , or items 23 r must be no Funeral	1 Never Married 2 Mar	Tied Armed Force 1 Yes rced If Yes, Give Year	2 X No		yes 2 X No		Puerto Rican, etc.)		White, etc. Specify: W	hite		
atural" saminel	3 Widowed 4 Divol	or Dates:	ompleted)	nd of work done		ind of Business						
5-0036 ed within 72 hour lygiene than "natu he Medical Exam	Elementary/Secondary (0-12)	College (1-4 o	or 5+)		ist of working life istrate		se retired)	Un	iv of	MD		
21215-0036 and be filed within 7 Marked other than marked other than c event, the Medica fo Be Compile	17. Father's Name (First, Middle, L	_				18.Mother's	Name (First, Middl	e, Maiden S	Surname)			
2121 could be fil d Mental I s marked tic event,	Matko Lee Ch 19a. Informant's Name/Relationsh	ullin III	I bbom	T 19b. Mailing	Address (Stree		rol Rae er or Rural Route N			e. Zip Code	e)	
MD 2 d 2 shou lith and P n 27 is n umatic	Matko Lee Ch	ullin II	Ι	408	Oriole	Ave	Baltimo	re M	D 2122	4		
	20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	State	Place of Disposi crematory or oth lantic	er place)	1	Date 04/26/1		ocation - City o			
Baltimore, permit. Pages 1 an Department of He Important: If ite	4 Donation 5 Other Spe 21. Signat of Fon Service L	ecify:	AC				Simplic					
	23a. Part I. Enter the disease, or c	4h	ad the death	Th	omas A	llen	P.A. 70	90 R	idge R	d Ha	noverM	
Physician Wedical Physician	failure. List only one cause of Immediate Cause (Final disease	omplications that caus in each line. a. Asphyxia	ed (ne death.	. Do not enter th	e mode or dying	, such as cal	diac of respiratory	arrest, snot	SK, Of Heart		en Onset and Death	
Examiner	or condition resulting in death)	Due to (or as a cor	nsequence o	f):								
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760, cate be ex physician he burial	IF FEMALE:	23c. If yes, outo	come of preg	nancy				23d.	. Date of delive	ry		
tox 6876(eath certificate attending physfor use as the bright for use as the bright attending physfor use as the bright attending physfor use as the bright attending physfor use as the bright attending to the bright attending the bright att	23b. Was decedent pregnant in the past 12 months?	4 Pregnant	at time of de	oth - H	al death 3 er (Specify)	Ectopic p	pregnancy	- ['	Month	Day	Year	
D. Box t the death of the attent ached for us Physic	Part II. Other significant condition	a Oliviowii		esulting in the u	nderlying cause	given in Part	1. 23e. Die	d tobacco u	ise contribute to	the cause	of death?	
ords, P.O. w requires that the sas been signed by should be detact		gonang to do	att Dat Hot I			9.1.0			No 3 Pro			
Division of Vital Records, 1st after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed								topsy	prior to		lings available of cause of	
Recor The law r ficate has b page 2 sh					00 PI-	1 D - 1 / 1	1 Ye	rformed? s 2 ✔ No	death?	'es	2 No	
of Vital Recting Physician: The Alter this certificate funeral director, page On: To Be Con	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2	ER/Outpatient			Check only one) Nursing Home 5	Residen	nce 6 🗸 Othe	er: Scene		
n of ding Ph After t funeral	27. Manner of Death	28a. Date of I	njury y,Year)	28b. Time of In FOUND:		iry at Work? Yes 2 ✔ N	28d Describ					
Division or pital or Attending to ours after death. Beral Director: At filled in by the fur	2 Accident Invest	igation Apr 24, 201	12	1725 hrs ome, farm, stree			28f. Location		nd Number or R	ural Route	Number, City	
Divi Bospital or 24 hours afte Runeral Div tely filled in	4 Homicide determ		Single Fan	nily Home			109 Oella A	n, State) Avenue, C	atonsville, MI)		
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be deached for use as the beached fifted than the funeral director, page 2 should be deached for use as the beached for use as the beac	(Officer of the	ysician: To the best of tiner:On the basis of e	xamination a	•)	
To roor	29b. Signature and title of certifier	and manner state	ea		29c. Licens				ate signed (Mo	onth, Day, Y	/ear)	
	Mlu Bro	y, me)	(20-)	O.C.	M.E.		April	25, 2012			
1	 Namé and address of person v Melissa Brassell, MD 	who completed cause of Assistant Medic	_ `		. Baltimore S	Street, Ba	ltimore, MD 21	223				
State Registrar	31. Date filed (Month, Day, Year)		trar's Signatu	bar	lad							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and N	/lental Hyg	giene	1220
			***************************************	ertificate of Death		Reg. No. 20	2 1320
п	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th 12 20	3. Time of Death 12 12:20 PM
٧	Medio Examir		Mildred Cohen 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of De	
	Laaiiiii	er	Greyswood Assisted Living	Bethesda		Montgo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		117-12-4141 1 □ M 2X□ F 95 Yrs.	Months Bays Hours Min.	3-21-1		New York
	and show at	ا ة	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Maryla 18a-f	Director	MD Montgomery Betheso	la			1 🏋 Yes 2 □ No
	a or 2		10e. Street and Number	10f. Zip Code	1	10g. Citizen of What	
	th with mrs 23 must	Funeral	6602 Greyswood Rd.	20817		United Sta	ates
.	or iter		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.
9	rs afte ral", Exan	ed b	3 XWidowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify:	White
21215-0036	2 hour	Completed by		edent's Usual Occupation e kind of work done during most of worki	ina	16b. Kind of Busines	ss/Industry
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ılan	d be fi dental irked tic ev	မ	Joseph Jolles	Esther E		,	
Maryland	should and N is ma	113		ling Address (Street and Number or Rura			' '
کر'	and 2 s Health tem 27			Hungerford Dr., Ro	ockville		
Jore	ge 1 and to the straight of the straight or ot			ematory or other place)	Date	20c. Location - City	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			srael Cem. 4-22-		Oxenhill, sky-Goldb	
Ba	Depar Impo any ir			1170 Rockville Pike			
r	hystelan/	£ 08	23a. Part 1. Enter the disease, or comblications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac of AHanosclantic			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to or as a consequence of):	7. 191 104 9	101 111		
		er	Sequentially list conditions, b				
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
	ate be executed physician and the burial-transit	EX	that initiated events resulting in death) Last C. Due to (or as a consequence of):		_		
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687	as g	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	ath ce attend for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of o	delivery Day Year
. B	is that the death certigned by the attending be detached for use	Physician/Me	1 Yes 2 PNo 4 Fregiant at time of death 5 9 Unknown				
P.O.	s that gned k	۾	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ds,	require been sign	ted			1 🗆 Y	es 2 Le No 3 □	Probably 4 Unknown
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/ita	ysician: s certific director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Checkert 3 DOA Other:		ence 6 🗌 Other (Sp	noife)
of	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury			ow injury occurred	эспуу
ion	tendir leath. :or: Af the fu	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Atten after deat Director: I in by the	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
	spita hours neral y filled	edical	29a. Certifier 1 Le Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cau	use(s) and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Med	(Check 2 Medical Examiner: On the basis of examination and/or inveonly one) 3 Certifying Nurse Practitioner: To the best of my knowledg	estigation, in my opinion, death occurred at	t the time, date an	d place, and due to th	e cause(s) and manner state
	7 with		29b. Signature 3nd title of certifier	29c. License number	2	29d. Date signed (Mor	nth, Day, Year)
			30. Name and address on person who completed eause of death (Item 23a) (Type.	Drint)	1	THULLI	JUI -
	20 V		30. Name and address of person who completed eause of death (Item 23a) (Type, SANY F. LAFTAL 54/3 W. CALAL	LANG #203C 139	THUSDA	MARYLAND	2084

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23^{ay} April 2012^{ear} 5:37 P M Emily Carroll Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours 164-24-1236 Director 88 1 🗆 M 2 🗓 F May 26 1923 Pennsylvania Usual Residence of Deced 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Worcester Ocean City 1 Yes 2 X No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 14007 Barge Road 21842 U.S.A. items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1

X Yes 2

No If Yes, Give 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 X Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic mach. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alice Marcy Carl Merritt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Prod Townson Marvland 21286 19a. Informant's Name/Relationship (Type, Print) 902 Stone Barn Road Towson, Maryland Carroll / Son Dennis 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State HilltopServiceCorp 4/27/2012 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of Faciliti Ruck Towson Funeral Home, Inc. 1050 York road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Phy ician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, than, reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events This to fee as a properties of and resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria /Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Watural injury work? 1 \(\text{Yes} \) 2 \(\text{No} \) 5 Pending neral Director: A rilled in by the fi Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a

To the Funeral

completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certif 29b. Signatu

State Registrar 6701

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Toniso Num

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address of person who completed cause of death (Item 23a) (Type, Print)

NB

31. Date filed (Month, Day, Year)

HOUES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 Virginia Elizabeth Carter 2012 12:11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Min. Hours **Director** 228-32-6507 1 ☐ M 2XX 80 09/25/1931 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 No Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8015 Gannett Court 21144 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married þ 1 Yes If Yes, Give Maryland 21215-0036 within 72 hours after 2 X No 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry id be filed with...
d Mental Hygiene...
ad other than "r
the Mr (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Thomas Owens Rosie Breeden should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mr. Robert L. Carter / husband 8015 Gannett Court, Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🛮 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 4/30/2012 Crownsville, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility 12nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, ark an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Phyllician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a co sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phys the attending plant of the season IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death the 9 Unknown Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 100 Other: မ 1 🗌 Yes 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \sum Yes Certificate: 28d. Describe how injury occurred injury 5 Pending neral Director: A filled in by the f Accident Investigation 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 26,2012

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who co

leted cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Ing Ping Chiou Physician/ 2012 11:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days May 31, Months Hours 219-04-3810 **1**925 Taiwan Director 1 🕅 M 2 🗆 F 86 3a or 28a-f show be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Rosedale 1 □ Yes 2 🛚 No Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ms 23a or must be n 21237 Funeral 10 Balistan Ct. United States "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 □ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) accounting Health and Mental Hygiene. accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) A Chun Chiou ည Lin Chuan Chan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Germantown, MD 20874 13522 Sanderling Place Tracy Lin/daughter 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory Apr. 25,2012|Baltimore, Maryland 4 Donation 5 Other (Specify) John O. Mitchell IV, Funeral Services of Dutan. John O. F. Padonia Rd. Timonium, MD 21093 Valley, P.A. Signature of Funeral Service Licensee 200 E. <u>Padonia Rd.</u> 23a. Part 1. Enter the disease, or complications that seems speck, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Yes been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Nο 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 🗌 Yes 2 🗆 No Yes 2 X 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending 1 \sum Yes Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29b. Signature and t

State
Registrar

DHMH 17 Rev 06-2011

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:18 P. M Allen Jackson Croft April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Baltimore Towson 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Hours 233-50-1617 Director 1 🕅 M 2 🗆 F 76 May 9, 1935 West Virginia Usual Residence of Deceder ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events any injury or other traumatic events. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2X No Maryland Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 8101 Bellona Avenue 21204 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 X Yes 2 No
If Yes, Give 10 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced Year or Dates. 1955-58 Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) years Computer Operator Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thelma Hall Η. Croft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23456 4297 Spruce Knob Road Virginia Beach, Virginia Kelli Croft (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 4-26-12 Baltimore, Maryland Signature of Funeral Service Licensee tchell-wiedefeld Funeral Home, Inc. 500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21212 shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician, Onset and De th disease or condition resulting in death) Medical Due to r as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year signed by the a ld be detached f 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 43513120 4V Hospital 2 NNo Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b 29c. License number 29d. Date signed (Month, Day, Year) 20 20 ss of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

State Registrar 45

Registrar's Signature

DCY

31. Date filed (Month, Day, Year)

TONSON MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death APRIL ILDA CASALENA 1:05 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PARKVILLE BALTO. OAK CREST CARE CENTER Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 86 Davs Hours 219-42-6797 1 🗆 M 2 🔀 F 12-26-1925 ITALY Usual Residence of Deced 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits **PARKVILLE** 1 Yes 2 XNo MD. BALTO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 WALTHER BLVD. APT. 313 USA 21234 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 🗙 No Specify: WHITE Specify. 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CLOTHING FACTORY **SEAMSTRESS** 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALFONSO CILLI ANNA DEFEBO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PERGLEN ROAD NOTTINGHAM, MD. 21236 SON 9302 ALFONSO M. CASALENA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) GARDENS OF FAITH 4-27-2012 BALTO.MD. 21. Signature of Funeral Service SCHIMUNEK FUNERALHOME, INC. 22. Name and Address of Facility 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure nly one cause on each line Immediate Cause (Fige disease or condition resulting in death) erebrovascu Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of)

Physician Medical **Examiner** Examine

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burial

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executed

that the death certificate be

Division of Vital Records, P.O. Box 68760

or Attending Physician: The law requires

this

filled in by the

completely

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

5V

Physician/

Medical

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Director

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Hygiene.

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Department of Health ar Important: If item 27 is any injury or with

the Medical

Baltimore, Maryland 21215-0036

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Examiner must be notified

Director

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Completed

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Physician/Medical signed by the a Completed by page 2 funeral director, Be မ Certificate:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (Chec.	k only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	1986 Diaco of Injury At home form atreat factor, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 L Medical Exar	vician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurred a ree Practitioner: To the best of my knowledge, death occurred at the time, date and place.	t the time, date and place, and due to the cause(s) and manner stated

23

Packs 112 MD 21234

2012

Registrar

State

DHMH 17 Rev 06-2011

8800

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Ma	arylanc		ırtment of F <i>tificate of D</i>		-		012	13207
Blooming		Registrar 1. Decedent's Name (First, Middle, Last)			001	inoato or E		2. Date of Dea		V	3. Time of Death
Physic Med	lical	Mary E. Caulk 4a. Facility Name (if not institution, give si						April		2012	8:00 P M
Exam	iner	Ridgeway Manor Nu:	*	Reha	ıb	4b. City, Town, or Catonsvi	Location of Death		4c. Coun Balti	more	
Funera		Social Security Number 6. Sex	7. Age	(In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Yearl	9. Birthp	place (State or Foreign
Directo	r	212-16-8352 1 Dusual Residence of Decedent]м 2 X] F		92 yrs.			Jan. 6	, 1920	Mary:	**
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with the s 23a c	Funeral Director	5743 Edmondson Ave	•			21228		1	U nited		
ter death , or item miner m	by Fur		12. Was Decedent E Armed Forces? 1 Yes 2 X		If	Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto		В	ace - Americ lack, White, e	etc.
ours af			If Yes, Give Year or Dates.			Yes 2 X No				Ty:White	
n 72 ha	Completed	(Specify only highest grad	e completed) College (1-4 or 5	<i>L</i>)	(Give k	ent's Usual Occupa ind of work done d) NOT use retired)	ation luring most of work	ing	16b. Kind of	Business/Ind	dustry
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be file ental H rked of	To B	17. Father's Name (First, Middle, Last) Frank H. Boettinge:	r				18. Mother's Nam Anna R.		Maiden Surnar	ne)	
offe, Intelligible A. I.		19a. Informant's Name/Relationship (Typ Diane Rapalyea / I			19b. Mailin 42 Bei	g Address (Street a	and Number or Rura Beverly	MA 019	r, City or Town, 915	State, Zip C	Code)
Page 1 an ment of He ant; If item ury or other		20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	cei	metery, crem	sition (Name of eatory or other place edral Cen	e) !	Date 27,2012	20c. Location	-	
permit. Page 1 Department of Important; If it any injury or o		21. Signature of Lineral Service Licenser	Och	_			s of FacilityAMB	ROSE FUI	NERAL H	OME, I	
		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused	the death.							Approximate Interval Between
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eath certific attending p		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o						23d. D	Date of delive	ery
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ing Physician: The la h.h. h.h. After this certificate ha funeral director, page	1	27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day,	y 2	28b. Time of injury	28c. Injury work	at /	28d. Describe h			
or Attendation of Att	Certificate	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.		ne, farm, stre		res 2 🗆 No	28f. Location (S City or Tow		ber or Rural	Route Number,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		er: On the basis of ex	amination a	and/or investi	gation, in my opinio	n, death occurred at	the time, date a	nd place, and d	due to the cau	use(s) and manner stated.
To the within To the comple	Σ	only one) 3 Certifying Nurse 29b. Signature and title of certifier				20- 11			001.01.	100000	D
		> Creetra Raya	un)	-		1127	541		April	as,	2012
		30. Name and address of person who co				S Farry	Ad, B	altmo	ne, M	10-2	1837
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 2 7 201		r's Signatu	1. 6	wed					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 April 23 1:45 P M Lourdes Carvajal Juana Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2900 Franklins Chance Drive Fallston Harford Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Country, **Director** 215-70-3150 1 ☐ M 2**X** F Feb. 4, 1925 Cuba Usual Residence of Decedent ms 23a or 28a-f show must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Harford **Fallston** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2900 Franklins Chance 21047 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 → Yes 2 □ No Specify: Specify: 3 Widowed 4 Divorced Completed White Cuban Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher Public Education Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ္ Bernardo (unk) Saque Nestora (unk) Urrutia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tranonce. Fallston, MD 21047 2900 Franklins Chance Drive, <u> Lourdes Z. Keiser / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Highview Memorial Gdn 4-26-2012 Fallston, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the o shock, or heart fai sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 8/0 week disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dusito (or de a consequence di): burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a ld be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 24/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORRISVICLE LO State Registrar

12-03116 Kelly J. Duffy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

elly J. Duπy		1- For State Reg. No. 20 2										2	1320
Physici		Decedent's Name (First, Midd	•						2. Date of Dea	ath	Year	3. Time of	
edical Exami	inei	Kelly J. Duff 4a. Facility Name (if not instituti		,		4b. City, Town,	or Location	of Death	Month April 22, 2		County of Deat	0341	hrs
		SB Route 32 at Fox (1	West Frie) Of Deau			oward	n	
Funeral		5. Social Security Number	6. Sex 7. Age	ge (In yrs. last	birthday)	If Under 1 Y		der 24Hrs.	8. Date of Bir	rth (MM/D	D/YYYY) 9. Bi		ate or
Director		215-31-2416	1M 2X_F	23	Yrs.		ays Hour	rs Min.	Sept.	22,1	988 Forei	ountry)	MD
any		Usual Residence of Decedent 10a. State 10b. County		Inc. City. To	own or Location	on						Tand Insid	le City Limits
E		,	altimore	100. Oily, 10		sor Mil	1						es 2 X No
arylane 8a-f sl	Director	10e. Street and Number	IIIIIIII		WILL	10f. Zip Code			1	0a. Citize	en of What Cou		
with the Maryland ms 23a or 28a-f show be notified at once.		1923 Greengag	ze Road		1	2114	4 2124	44	ľ	USA			
h with	Funeral	11. Marital Status	12. Was Decedent		13. Was		Hispanic Or	rigin? (Spe	ecify Yes or No		14. Race - Amer	rican Indian,	, Black,
or deat			1 Yes 2	X No					Klean, etc.)		White, etc.	n	
ırs afte tural" puine	d by	3 Widowed 4 Di	ivorced If Yes, Give Yeer or Dates: ecify only highest grade com	noleted) 16		Yes 2 X I			ork done		Specify: Wind of Business/	hite	
72 hou	Completed	Elementary/Secondary (0-12)			during mo	ost of working I						made.,	
)036 vithin ene. er tha	d m		1		Wai	itress					stauran	ıt	
15-C		17. Father's Name (First, Middle Michael Duffy	. ,				1		(First, Middle, M Ho1zman		urname)		_
212 Auld be Menta mark	lo Be	19a. Informant's Name/Relations			19b. Mailing	Address (St					y or Town, State	e. Zip Code	1
MD 12 sho th and a 27 is		Michael Duffy	- Father								11, MD		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal from Str		nce of Disposit	tion (Name of e	cemetery,	T	Date	20c, Lo	ocation - City or	Town, State	e
Page ment o		4 Donation 5 Other S	Specify: /		st Lawn	n Mem.					rriotts		-
Balt Depart Impor		21. Signature of Funeral Service	Licensee		Fun	neral H	ome o	f Cat	consvil:	le, :	n Schwa Inc.		
Physician	\dashv	23a. Part I. Enter the disease, or	or complications that caused	the death. Do	l163	30 Edmo	ndson	Aver	nue: Cai	tonsy	ville.		228 mate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	e on each line.								7	Between	n Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse									+	
	Ē	Sequentially list conditions, if any, leading to immediate	b	equence of);								+	
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ited d ansit	Еха	events resulting in death) Last	Due to (or as a conse	quence of):									
60, ite be executed hysician and burial - transit	ledical	UNPENDED	AMENDED									+	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE:	23c. If yes, outcom	ne of pregnan	псу					23d.	Date of deliver	<u></u>	
Box 6876. he death certificate y the attending phy hed for use as the l	Physician/N	23b. Was decedent pregnant in the past 12 months?	tne 1 Live birth	time of death	2 Feta		3 Ectopi	ic pregnan	су			Day	Year
Box: death	nysi	1 Yes 2 No 9 🗸 Un			o ∐ Otre	er (Specify)			-				
P.O.	by P	Part II. Other significant condit	itions contributing to death	but not resul	Iting in the un	derlying caus	e given in P	art I.			se contribute to		
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of Vital Records, is Physician: The law require there this certificate has been sineral director, page 2 should b	Completed								24a. Was a autops	sy	24b. Were au prior to death?	utopsy finding completion o	
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sician:	Be	25. Was case referred to medica examiner?	Hospital: 1 Inpatier	ent 2 FR	R/Outpatient		Other4			Dasidenc	ce 6 🗸 Other	r Scene	
n of V ding Phy After thi funeral d	유	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	iry 281	Bb. Time of Inj		njury at Work	k? 2	28d. Describe h	now injury	y occurred		
ision Attendin or death. rector: A by the fu	atio		Apr 22, 2012	03	317 hrs	1	Yes 2	No L	river in mo	tor ven	nicle collisio	n	
Division tal or Attendit rs after death. al Director: A led in by the fu	Certification:	3 Suicide 6 Cou	ald not be 28e. Place of Inju			, factory, office	e building, e		or Town, St	tate)	d Number or Ru		
Divi		29a Certifier	ermined (Specify) Maj						BB Route 32 a	at Fox C	hase Road, V		dship, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Critical Orly)	Physician: To the best of my aminer:On the basis of exam										
F With	Me	29b Signature and title of certific	and manner stated, er			29c. Lice	nse number			29d. Da	ate signed (Mor	nth, Day, Ye	ar)
/		/ Il calaber	M			0.0	C.M.E.			April 2	22, 2012		
BU	ľ	30 Name and address of person			,								
			Assistant Medical Exa		00 W. Ban	timore Stre	et, Baltın	nore, M	D 21223				
St Regist	tate	31. Date filed (Month, Day, Year)		s Signature	he	Kal							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ uline Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Riverview Nursing Center Essex If Under 24 Hrs. Hours Min. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-28-6759 Months Days (Month, Day Country) **Director** 1 □ M 2 🔀 March16,1930 MD 82 Yrs Usual Residence of De show 10c. City, Town or Location at 10d. Inside City Limits Director notified Baltimore MD Essex 28a-f 1 Yes X No 10e. Street and Numbe 10f. Zip Code č 10g. Citizen of What Country? must be Funeral 23a 252 N. Marlyn Avenue 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by ò 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", 3X Widowed 4 □ Divorced If Yes. Give Specify Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Homemaker own home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Lutz Margaret Uhler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
252 N. Marlyn Avenue Baltimore MD 21221 Terry Diehl /son f Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Baltimore MD Parkwood Cemetery 4/27/12 4 Donation 5 Other (Specify) Signature of Euge Service Licen 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital ျှ 1 Tyes 2 **N**O Other Nursing Home 5 Residence 6 Other (Specify) this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After (Month, Day, Year) 5 Pending Natural 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per Dyn 6926 4/27/2012 The of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Henrietta Helena Diluca 10:52A M 04 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 913 Langley Road Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 216-16-1989 Hours Director 1 □ M 2 🔀 F 87 Maryland 06/22/1924 Usual Residence of Decede or 28a-f shov 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD 1 🗆 Yes 2 🔀 No Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 913 Langley Road 21061 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 ☐ Yes 2 X No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Coppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Arthur Graham Johanna Kne11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Diane Diluca / Daughter 310 Marie Avenue Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Glen Haven Mem. Park | 04/27/2012 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee MO1479 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Maga Medical Due to (or as a consequence of) **Examiner** (nu gain Sequentially list conditions, if any, bearing to humediate cause. Enter Underlying Cause (Disease or injury Examiner Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Pregnant at time of death Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy autops, performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 <a> Nursing Home 5 ■ Residence 6 □ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation Accident Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie

Registrar DHMH 17 Rev 06-2011

State

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MIRZA M. NUSAIREL M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1401 MADISON

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

PARK #100

29c. License number

20040519

29d. Date signed (Month, Day, Year)

4-24-17

FLAN BIRNIC MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 13212 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Linthicum 204 Nancy Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Z. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 211-18-1089 Director 1 M 2 M 85 Yrs 05/28/1926 PA Usual Residence of Deced 28a-f show 10b Count 10a State 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2K No Anne Arundel Linthicum MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21090 U.S.A. 204 Nancy Avenue items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify "natural", 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Executive Secretary Legal event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked ot r other traumatic ever ည Schreiber and 2 should be David Donnelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 22401 Fredericksburg, VA Mrs. Donna Jones / Daughter 1309 Parcell Street Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 04/25/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) MO1479 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licenses Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ 010 disease or condition Medical resulting in death) Due to (or s Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) nding physician ause as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as i yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy jo in the past 12 months
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death / the a 9 Unknown been signed by i should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l autopsy this certificate 21 25. Was case referred to medica examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: မြ 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Cher (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the 1 only one) 29b. Signature and 29c, License number 29d. Date signed (Month, Day, Year, 30. Name and address of person cause of death (Item 23a) Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

APR 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 5.35 PM Dye Merle Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square 1405 oita 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex **Funeral** Days Hours Months 213-62-4224 Maryland September 15,1954 **Director** 1 XM 2 □ F 57 Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location aţ Director Examiner must be notified 1 Yes 2 XNo Maryland Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 7520 School Avenue 21222 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3X Widowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I and 2 should be filed within 72 f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Forklift Operator General Electric 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Arthur Dye Tnez. Meagher Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erin Dye 1247 S. 48th Street, Dundalk, Maryland Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April^{Pate}30, Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 2012 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Igna ure of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do put enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph. sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ь Pregnant at time of death 5 Other (specify) should be detached Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an nas page 2 performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ျ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No death. M filled in by the Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

yedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature a 29c License number Res 0000 completed cause of death (Item 23a) (Type, Print) 9000 Square Drive Baltimore, MD State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 22:10M ne Medical Facility Name (if not institution, give street and number, 4b. City, 4c. County of Death Examiner P ano If Under 2 . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 Months Min (Month, Day, Year) 10/1954 Milford 57 **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director New Castle DE New Castle 1 Yes 2XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 19720 United States 409 9th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc 1 X Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State of Delaware Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Correction 12th Correctional Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen V. Billups John T. Edwards 19a. Informant's Name/Relationship (Type, Print) 19), Mailing Address (Street and Number of Rural Bouts Number Chester, Zip Code) 613 Bowers Drive West Number of Rural Bouts Number Chester, Pennsylvania 19382 John T. Edwards II Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4/24/12 Silverbrook Wilmington, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evan W. Smith Funeral Svc. . Signature of Funeral Service Licensee DE 19805 201 N. Union St. Wilm., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE TO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ESUPHAGEAL SUSPECTED Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as 1 IF FEMALE use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) the 9 Unknown g Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, HEMIPLEGIA FROM CERETSRUVASCULAR or Attending Physician: The law requires 2 No 3 Probably 4X Unknown 1 Yes the funeral director, page 2 should ACCIDENT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of CHRONIC RENAL FAILURE has autopsy performe death? this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be after death Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinating and/or investigation. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and/title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 00415 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W

Registrar

State

Helen Andrews Noble

APR 2 7 2012

31. Date filed (Month, Day, Year)

. Registrar's Signat

122 Speers RD STE-5 Chestertown, MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ April 10:25AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice sattimore OWSON 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours Director 1 M 2 D F May 6. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director atons vil 1 Yes 2 No Baltimore 5 10g. Citizen of What Country? pe tems 23a Funeral 21228 must b 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 Married "natural", or 1 Yes 2 110 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Divorced 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid 2 lames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City _eoc 101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If it any injury or o oţ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sign Jury of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physicians. nonth disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): the burialphysician Completed by Physician/Medical as t IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death the 9 Unknown Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? inject con 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has page this certificate 1 Yes 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital

> State Registrar

31. Date filed (Month, Day,

Medical

Accident

4 Homicide

29a. Certifier

(Check

Suicide

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie

Investigation

determined

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

pril 21, 2012

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who com 3a) (Type, Print) ed cause of death

within 24 hours after death. To the Funeral Director: A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month PEGGY J. FOREMAN APRIL 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNIT 405 12330 ROSSLARE RIDGE ROAD TIMONIUM BALTIMORE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 □ M 2 🛛 F Months Days Hours Min Director 249-44-6836 SOUTH CAROLINA Usual Residence of Decedent or 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 🔯 No TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12330 ROSSLARE RIDGE ROAD 21093 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 XNo Black, White, etc. Š 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 Divorced 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th HOMEMAKER OWN HOME 10TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည L.B. WATFORD MAUDE L. EATON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unit 405 12330 ROSSLARE RIDGE RD. TIMONTUM, MD 2 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau P.J. FOREMAN/HUSBAND 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEM. PARK 4/28/2012 HILLENDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1 THE JOHNSON FUNERAL HOME, P.A. Hai 8521 LOCH RAVEN BLVD. TOWSON, MD if 1. Enter the dis ≠se, or o on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List on vone cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ obstructure isease or condition resulting in death) pulmonary Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabetes, hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Tes 2 No 1 Tyes 2 1 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 212 No Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year)

Y

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D53968

2 LC ross roads Drive Stute 400 Owings Mills MD 21117

25,2012

			For State of N	1aryland / Depa			lental Hygie	ne	0 10017		
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	eatn	Reg. 2. Date of Death	No. ZU	3. Time of Death		
	Physicia Medic		Linda Lee Franklin					5 ^{Day} 2012	7:00p M		
	Examir	er	4a. Facility Name (if not institution, give street and number) 19 Parkview Terrace		4b. City, Town, or Lo			4c. County of Dea			
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	inster If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign		
	Director	ı	215-42-7956 Usual Residence of Decedent	66 yrs.	Months Days	Hours Min.	(Month, Day, Yea 10-15-19		ountry)		
	land show dat	호	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits		
	Mary 28a-f notifie	Director	MD Carroll		Westmi	inster			1X Yes 2 □ No		
	vith the 23a or st be r	ral	10e. Street and Number 19 Parkview Terrace		10f. Zip Code	1158	10g.	Citizen of What Co	ountry?		
	items	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-	14. Race - Ame			
36	72 hours after death with the Maryland n"natural", or items 23a or 28a-f show Aedical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Son Postos	No 1	Yes 2 No		iicaii, etc.)	Black, Whit			
21215-0036	hours natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation	on	166	o. Kind of Business			
121	thin 72 ene. than ' he Me	ook									
d 2	s filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	Be	12 17. Father's Name (First, Middle, Last)	Wai	rehouse V		(First, Middle, Maid				
ylaı	ould be fill od Mental marked c	입	Bill Eckard	5							
Maryland	Ith an	l	19a. Informant's Name/Relationship (Type, Print) Lorette L. Crown-daug!		g Address (Street and 2 Mill Ra						
ē,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat	20b. Place of Dispos				. Location - City or			
Baltimore,	t. Pag tmen rtant: njury		4 Donation 5 Other (Specify)	Lake Vie	ew Memori			kesvill			
Ba	permi Depar Impo any ir once.	Į,	21. Signature of Funeral Service Licen		Name and Address of 4 E. Mai						
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	d the death. Do not ente				, cci jiib	Approximate Interval Between		
-00	hysician/ Medical	i		ed Ischem	nic Cardi	omyopa	thy	10	Onset and Death 6 months		
-	Examiner		Coro	Due to (or as a consequence of): Coronary Artery Disease							
	sit d	Examiner	Sequentially list conditions.	a consequence oi).	_			3 years			
	xecute n and al-tran:	Ехаг	that initiated events c	a consequence of):							
09,	cate be executed physician and the burial-transit	edical	d								
	ertifica ding pl	/Me	IF FEMALE: 23c. If yes, outcome	e of pregnancy			- WE				
Box 687	death c e atten ed for u	Physician/M	in the past 12 months? 1 Live Birth 1 Ves 2 No. 4 Pregnant	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
P.O. I	at the o		g Unknown 9 Unknown Part II. Other significant conditions contributing to death	but not resulting in the ur	derlying cause given	in Part I	Ola Did takana		the cause of death?		
IS, P	requires that the death certific been signed by the attending p should be detached for use as	ed by							robably 4 Unknown		
corc	aw requas beer 2 shou	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of		
Re	sician: The law sicertificate has be lirector, page 2 s						performed		s 2 🗆 No		
Division of Vital Records,	ysician: is certifica director,	To Be	25. Was case referred t edical examiner? 1 Yes 2 No Hospital: 1 Inpar	ient 2 ER/Outpatient	Other:	of Death (Check	only one) ne 5 D Residence	6 Other /Spac	35.4		
Jo u	ing Phys After this 'uneral di		27. Manny of Death 1 Natural 5 Pending 28a. Date of inj (Month, De	ury 28b. Time of	28c. Injury at work?	2	8d. Describe how in		niy)		
sior	Attend r death ctor: /	Certificate:	2 Accident Investigation	ury - At home, farm, stre		s 2 No	8f. Location (Street	and Number or Ru	ral Route Number		
DΪΧ	Hospital or Attending I 24 hours after death. Funeral Director: After stely filled in by the funer		building, et	c. (Specify)			City or Town, Sta	ate)			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The The Tearla Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of Check 2 Certifying Nurse Providence Telephone Telephone (Check 2 Certifying Nurse Providence Telephone (Check 2 Certifying Physician: To the best of Certifying Physician: To the basis of Certifying Physician: To the basis of Certifying Physician: To the best of Certifying Physician: To the basis of Certifying Physician: To the best of Certifying Physician: To the basis of Certifying Physician: To the Certifying Physician: To the basis of Certifying Physician: To the basis of Certifying Physician: To the Certifying Physi	examination and/or investi	gation, in my opinion, o	death occurred at f	the time, date and pla	ace, and due to the o	cause(s) and manner stated		
	To the within 2 To the comple	2	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier		29c. License nu	ımber		use(s) and manner a Date signed <i>(Month</i>			
			The K. Galma		D316	.60	4	26/2012	-		
)			30. Name and address of person who completed cause of a THOMAS K. CALYIN I			ER AVE.	WESTMI	INSTER, A	ND 21157		
Ī	Stat Registra	e		ar's Signature							

DHMH 17 Rev 06-2011

		1 - State of Maryland State of Maryland	/ Depa		t of H	ealth a		1ental Hy	•	e. 2. 13218
Physicia Medic Examin	al	Decedent's Name (First, Middle, Last) Lisa Mae Givens 4a. Facility Name (if not institution, give street and number) Joseph Richey Hospice			Town, or	Location o	of Death	2. Date of De Month	ath Day Yea 4c. County of Di	1100 a M
Funeral Director		5. Social Security Number 218-74-6639 6. Sex 1 \square M 2 \boxtimes F 46	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da Sept. 1	y, Year)	Birthplace (State or Foreign Country) ennsylvania
ie Maryland ir 28a-f shov notified at	Director		Town or Loc		Code				10g. Citizen of What	10d. Inside City Limits 1 TY Yes 2 □ No
with the s 23a o	Funeral	5522 Selma Avenue			1227			ľ	U.S.A.	Country?
tore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The file may 7 is marked other than "natural", or items 28a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	۵	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2	2 X No	Specify:		cify Yes or No- Rican, etc.)	14. Race - Ar Black, Wl Specify: W]	
Maryland 21215-0036 12 should be filed within 72 hours after tith and Mental Hygiens 27 is marked other than "natural", or traumatic event, the Medical Exami	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 1 College (1-4 or 5+)	life. DO	lent's Usua kind of work O NOT use omemal	k done du retired)	tion uring most	of workii	ng	16b. Kind of Busine	•
Maryland should be filed and Mental Hy r is marked oth	To Be	17. Father's Name (First, Middle, Last) David Leroy Baker						e (First, Middle, e Combs	Maiden Surname)	
d 2 shot alth and a 27 is n		19a. Informant's Name/Relationship (Type, Print) Kara Hall (Daughter)							r, City or Town, State, Son,MD 21:	
Baltimore, permit. Page 1 and Department of Heat Important: If item 3 any injury or other once.		1 Burial 2 Cremation 3 Removal from State Cer	ice of Dispo metery, crem ience	natory or ot	e of her place	9 4		Date 2012	20c. Location - City	
Balt permit Depart Import any inj once.		21. Signature of Funeral Service Licensee	22 Me	Name and	Address	of Facility n Fu	nera Alex	1 Servi	lce VA 22310	
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			of dying	, such as	cardiac o			Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) Due to (or as a conseque) Sequentially list conditions, b.	nce of:							
executed an and ririal-transit	ical Examiner	riany, Leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cons								
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live Birth 2 Feal 4 Pregnant at time of de 9 Unknown	death 3 🗀	l Ectopic p	regnancy ecify)	,		-	23d. Date of o Month	delivery Day Year
ds, P.O. quires that the en signed by to ould be detack	þ	Part II. Other significant conditions contributing to death but not resul	ting in the u	nderlying c	ause give	en in Part I				to the cause of death?
3 8 8	Completed		_					1 Yes	prior t rmed/2 death	autopsy findings available o completion of cause of ? 'es 2 No
Vital vysiciar	To Be	25. Was case referred to medical examiner? 1 Yes 27 No Hospital: 1 Inpatient 2 E	R/Outpatien	t 3 🗆 DO	Other	ce of Deat 4 Nu			lence 6 Other (Sp	ecify) HOLDICL
ion of ending Pt eath. or: After the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	8b. Time of injury	28 M	lc. Injury work? 1 🔲 Y	at	2		ow injury occurred	
Division Hospital or Attend 124 hours after death Funeral Director. A letely filled in by the the		4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory,	office		1	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certiffer (Check only one) 1 Certifying Physician: To the best of my knowler Medical Examiner: On the basis of examination a 3 Certifying Nurse Practitioner: To the best of my	ınd/or investi	igation, in m	ny opinion	, death oc	curred at	the time, date a	nd place, and due to th	e cause(s) and manner stated.
To with con		29b. Signature and title of certifier		29c.	License	number HDD .	04210	7	29d. Date signed (Moi	nth, Day, Year)
Φ		30. Name and address of person who completed cause of death (Item 2	FBLOUR	rint)	327	المال	oden	Av	Bulh Ma	ग्रेग्रा
Stat Registra	.e	31. Date filed (Month, Day, Year) APR 2 7 2012 32. Registrar's Signatur	park							

1:00am

Lisa Givens 4-20-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21 Day 2012 ear APRIL 6:26 PM MARVIN AARON GILLMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 3107 Rolling Rd. Chevy Chase Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1**X**□ M 2 □ F Director 126-10-8342 94 Yrs Usual Residence of Decedent 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3107 Rolling Road 20815 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates. WW-II Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with n and Mental Hygien is marked other th Opthomologist Medical traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Gillman Tessie Grosse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 3107 Rolling Road, Chevy Chase, Maryland 20815 Lydia Gillman - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. cemetery, crematory or other placel 1 🛚 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Cemetery 4-25-2012 Hawthorne, New York Mt. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel 1091 Rockville Pike, Rockville, Maryland 20852 M00910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DECUBITUS ULCER Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) physician and the burial-transit death certificate be executed Cause (Disease or linjury DEMENTIA that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' VASCULAR ULCERS 1 ☐ Yes 2 ☐ No Yes 2 XN Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗎 No injury 5 Pending To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

100

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State Registrar

29b. Signature and title of certifier

VAMC,50 IRVING STREET NW, WASHINGTON, DC 20422/688 M.D., ROBERT MARK KAISER, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

#ME91750

29d. Date signed (Month, Day, Year)

APRIL 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Amend Items 23 State of Maryland / Department of Harling Manual Hygiene Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 1535 (evecin Medical 4a. Facility Name (if not institution, give str 4c. County of Death **Examiner** Baltimor If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 436-79-2858 Director 1**X** M 2 □ F 21 4, 1990 Aug Louisiana 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 10b. County 10c. City, Town or Location Director MD Baltimore White Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21161 U.S.A. 19601 Old York Road death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status þ 1 X Never Married 2 Married be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: "natural", Specify: Ameriasian 3 Divorced 4 Divorced Completed Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other thau Automobile Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Kil Y. Yanq Willie R. Green, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19601 Old York Rd White Hall, MD 21161 1 and 2 s f Health item 27 Willie R. Green Sr/Father Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apr. 21 Department of H Important: If ite any injury or otl cemetery, crematory or other place)
Stabler's Cem. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 2012 Parkton, Hartenstein Mortuary Inc ture of Funeral 22. Name and Address of Facility JJ 24 N. Second St. New Freedom PA 23a. Part 1. Enter the dis ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre-Approximate Interval Between Onset and Death Multiple Injuries shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition Physician. BETTERCHION AS PROPER OF MEDICAL CEMINICA Medical resulting in death) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Hospital or Attending Physician: The law requires that the death Day Month Year been signed by the a should be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? certificate 2 No Yes 2 funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) 1 X Yes 2 100 Other: 잍 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this . Date of injury (Month, Day, 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Subject Pass-28c. Injury at Certificate: enger in car over turned in field. 1 Accident
2 Accident
3 Suicide 5 Pending 2201M 12 Investigation 6 Could not be filled in by the e of Injury - At home, farm, street, factory, office ling, etc. (Specify) 28e. Pla 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nu er: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)
4 15 12 47 5 29b. Signature and title 53184 MD 100983 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bathmore, MD 21201 .22 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2012 9:25 PATRICIA GIST Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 6403 OAKTON WAY PRINCE GEORGE'S CHEVERLY 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year) Hours Country) **Director** 377-54-3085 1 M 2X F Yrs 61 APRIL 8, 1951 MICHIGAN 28a-f shov 10c. City, Town or Location 10b. Count Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director notified PRINCE GEORGE'S MARYLAND CHEVERLY 1 X Yes 2 No 10f. Zip Code 9 10g. Citizen of What Country? pe 23a by Funeral ural", or items 23a I Examiner must b 6403 OAKTON WAY 20785 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates BLACK event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than ' Elementary/Secondary (0-12) College (1-4 or 5+) COMMODITY TRADER PRIVATE other Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname, ည SHEFFIELD **HENDERSON** BRAZIL MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNEST GIST / HUSBAND 6403 OAKTON WAY, CHEVERLY, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 4/28/2012 BRENTWOOD, MARYLAND f Fund 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC, 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MALIGNANT NEOPLASM OF THE BREAST Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Dan to for as a nonsectionne cocause. Enter Underlying Cause (Disease or injury Exam burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 as the l IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Day Pregnant at time of death 5 Other (specify) Month Year be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be page 2 autopsy performed?

Yes 2 No death? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 🗌 Yes 2 XNo Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☑ Natural 5 \square Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar
DHMH 17 Rev 06-2011

State

Mel

200

ANP-B

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For	State of Marylan	d / Depa	artment of I	Health an	nd Mental Hy	giene	0010	10000
			1 - State Registrar		Cer	tificate of l	Death		Reg. No.	2012	13222
	Physicia Medic		1. Decedent's Name (First, Middle, Las		dn.	er, Si	R.	2. Date of Dea		3017	3. Time of Death
	Examir	ner	4a. Facility Name (if not institution, give	Hospital		4b. City, Town, o	4 1/ /	owh		unty of Death	nore
	Funeral Director			ex 7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Min. (Month, Da)	, Year)	Cour	place (State or Foreign http://
	rland f show d at	ţō	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo			10012	3 /13		10d. Inside City Limits
	the Man or 28a- e notifie	Director	MO CAR 10e. Street and Number	ROLL E	LOEI	2S BUR 10f. Zip Code	.6		10g. Citizen	of What Cou	1 XYes 2 □ No
	ath with ems 23a must b	Funeral	6829 1177.	12. Was Decedent Ever in U.S.	WRT	21	784	? (Specify Yes or No-	(<u>)SA</u>	an Indian
920	ırs after dez ıral", or ite I Examiner		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	1	f Yes, specify Cuba	an, Mexican, Pu	uerto Rican, etc.)		Race - Americ Black, White, cify:	
21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortants If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give I	dent's Usual Occup kind of work done O NOT use retired)	during most of	working		of Business/Ir	
Maryland 2	be filed w ental Hygi ked other c event, t	To Be	17. Father's Name (First, Middle, Last)	ANIEL GAV		_		Name (First, Middle,			_
ary	2 should th and Me 27 is marl traumati		19a. Informant's Name/Relationship (7)	/pe, Print)	19b. Mailir	ng Address (Street		r Rural Route Number			
	1 and 2 s f Health item 27 other tra		20a. Method of Disposition		lace of Dispo	sition (Name of		COUNT EL		SUNG- on - City or To	m0 21784
Baltimore,	oermit. Page 1 Department of Important; If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	mT	TABO	natory or other place. REM	1. 4/	30/2012	ETCHI	SON	MO
Ba	permit. Departn Importa any inju		21. Signature of Funeral Service Licens	mbrum	6	028 SY	ESVILL	INZUMB ERDE	ZOERS	BURG-	MO 217EY
	hysician/		23a Farth Anterthe disease, to comp shock, or heart failure. List only o immediate Cause (Final disease or condition	olications that caused the death ne cause on ach line.	n. Do not ente		ig, such as card		est,		Approximate Interval Between Onset and Death
-	Medical Examiner		resulting in death)	a. Due to (or a a consequ	ence of:	Robal	Co.	luee			
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):	, , , , ,					
_	ate be executed hysician and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
3760	ficate g phys as the	Medi		d							
Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 24 brours after death. Funeral Director, After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	death 3	Ectopic pregnand Other (specify)	гу		23d.	Date of deliv Month	ery Day Year
ls, P.O.	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions co	ontributing to death but not resi	ulting in the u	nderlying cause gi	ven in Part I.			ontribute to the	ne cause of death?
Records,	The law req ate has bee page 2 sho	Completed						24a. Was a autop perfor			psy findings available mpletion of cause of
Ita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Check only one)	V		
<u>\</u>	ding Physi h. After this c funeral dir	2	27. Manuer of Death	28a. Date of injury	ER/Outpatien	ot 3 DOA Oth	4 ∐ Nursin	ng Home 5 Resid)
Division of	tending F death. tor: After t the funer	Certificate:	Natural 5 Pending Accident Investigation 3 Suicide 6 Could not by	(Month, Day, Year)	injury	M 1 🗆					
DIVIS	Hospital or Attenc 24 hours after death Funeral Director; stely filled in by the		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow		mber or Rurai	Route Number,
	To the Hospi within 24 hou To the Funer completely fil	Medical	(Check 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination to Practitioner: To the best of m	and/or invest	igation, in my opinio	on, death occurr	red at the time, date ar	nd place, and	due to the ca	use(s) and manner stated.
	To the with Common Comm	183	29b. Signature and title of certifier	Des		29c. Licenso	3PS	0	29d. Date sig	L26	Day, Year)
Ü			Steven =	ompleted cause of death (Item	P3a) (Type, P	p Klo	rKu	rest the	Un te	260	en ten
	Stat Registra	te ar	31. Date filed (Month, Day, Year) APR 2 7 2012	32. Registrar's Signat	par	les			J		
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DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 HELEN GOLDMAN 12:04 A M В APRIL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER HOWARD COUNTY HOWARD COLUMBIA . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** g. Birthplace (State or Foreign Hours Min. (Month, Day, Year) 218-14-0560 Director 1 □ M 2 🕱 F 88 07/19/1923 MD Usual Residence of Decedent 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No BALTIMORE BALTIMORE 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4 CANDLEMAKER COURT 21208 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married "natural", or 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates WHITE the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MERIN **ABRAHAM ESTHER** SELLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE TAYLOR-FRIEDMAN/DAUGHTER 10 COACHMONT COURT, BALTIMORE, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MENS 04/24/2012 BALTIMORE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) tailure month Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine • Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and etelly filled in by the funeral director, page 2 should be detached for use as the burial-trans. rogressive that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown q | | Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Of Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 5 Pending Natural iniury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 1)0060632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 Yes 2 No

20904

Year

Box 68760 P.0. Records, Division of Vital Hospital or Attending Physician: within 24 hours arter co...
To the Funeral Director: Aftr

> State Registrar

funeral (

Medical

1 Yes

27. Manner of Death

1XX Natural

Accident

Suicide

4 Homicide

29a. Certifier

29b. Signa

(Check

only one)

2**X X**No

3 🗆

re and title

31. Date filed (Month, Day, Year,

5 Pending

Investigation

Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

DANIEL J. FERNICOLA, JR. M.D., 15215 SHADY GROVE RD. #306, ROCKVILLE, MD

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of injury

(Month, Day, Year)

28b. Time of

28c. Injury at work? 1 \square Yes

29c. License numbe

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 🗌 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

25

29d. Date signed (Month, Day, Year)

12

20815

12-03193 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John Michael Hayner 2012 13225 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Month Day April 24, 2012 Medical Examiner John Michael Hayner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1113 Gypsy Lane W **Baltimore County** Towson **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 216-38-4874 73 May 14, 1938 countr@alifornia 1 X M 2 F Usual Residence of Decedent iny 10a, State 10b. County 10c. City, Town or Location MD. Baltimore Towson permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Gypsy Lane West 21286 Funeral 11. Marital Status 12. Was Oecedent Ever in U.S. Was Oecedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 White, etc. Yes 2 X No Specify: White 3 Widowed 4 Divorced If Yes. Give Year 1 Yes 2 X No specify: 至 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. OO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Engineer Edgewood Arsenal 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Freeman Bernetha Thomas R. Hayner Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deon Jones/ Cousin Lynn Haven, F1. 32444 2623 Ferol Lane 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4-27-12 Hilltop Service Co. Towson, MD. 4 Donation 5 Other Specif 22. Name and Address of Facility Son Funeral Home, Inc. 21. Signature of Fu 1050 York Rd. Towson, MD. 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical a. Intraoral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Oue to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial IF FEMALE: 23b, Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✓ Yes 2 No 1 🗸 Yes director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ___ Natural Subject shot self FOUND: 5 Pending 1 Yes 2 ✔ No Apr 24, 2012 1301 hrs

Division of Vital Records, P.O. Box 68760, and or Attending Physician. The law requires that the death certificate be executed Hospital or Attending Physician: filled in by the Director: To the Hospital or Att within 24 hours after de To the Funeral Direct completely

or Town, State) 1113 Gypsy Lane W. Towson, MD (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 25, 2012 Dual

28e. Place of Injury - At home, farm, street, factory, office building, etc.

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Investigation

Could not be

determined

Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) APR 2 7 State Registrar

Accident

3 V Suicide

1311 hrs

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Year

2 No

28f. Location (Street and Number or Rural Route Number, City

101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thomas J. Heinlein 2012 9:35 Medical Apri 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center 8. Date of Birth (Month, Day, Year) August 27, 1955 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours **Director** 217-64-0195 1 X M 2 □ F 56 Baltimore, Maryland 28a-f shov at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Maryland Baltimore Nottingham 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9446 Seven Courts Drive 21236 United States items "natural", or item edical Examiner n . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.; Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 Yes, Give Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Me Elementary/Secondary (0-12) U.S. Postal College (1-4 or 5+) 12 <u>Postal Worker</u> Be 17. Father's Name (First, Middle, Last) I Health and Mensel fitem 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) ည John Joseph Heinlein Margaret Boland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anne Eckhardt (Sister) 4 Cameron Court Apt. J Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State April 29, 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel-Bel 4 Donation 5 Other (Specify) 2012 Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ luer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events the burial-tran attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 2012 Q D72139

DHMH 17 Rev 06-2011

Registrar

July 4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED B. ABBAS 6701 N Charles Sheet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 95% D 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical County of Death a. Facility Name (if not institution, give street and number) ocation of Death Examiner City, Town, or Retab HEALTH AND If Under 24 Hrs. 8. Date of Birth (Month, Day,) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Country) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Thomas Ru 21015 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education. 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) မှ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service HAR 23a. Part 1. Enter the disease, or complications that cars shock, or heart failure. List only one cause on experiments ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Exam er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. H39022 2012

State

Registrar

and address

31. Date filed (Month, Day, Year)

2 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 800 Pien 35 A M (orraine 2019 Medical 4a. Facility Name (if not institution, give street and number) 4b./City, Town, or Location of Death 4c. County of Death **Examiner** wesminste Dus !! 11000 15/10/17H Cente Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Months 265-52-1402 Hours 91 1 □ M 2 🏲 F **Director** 12-11-1920 PA Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 225 Frocks Dr., 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 🔀 Widowed 4 🗌 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Housewife the Homemaker Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rth and Mental H Page 1 and 2 should be f ment of Health and Menta ant; If item 27 is marked Wayne Hummel Beatrice Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry H. Heagy III-son 910 Bob-El Dr., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1
Department of Important; If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Tunnel Cem. 5/1/12 Elizabethtown, PA Mount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature Funeral Service I 254 Main St., Westminster, MD 21157 Approximate Interval Between Onset and Death HOW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes ≥ ₩ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by completely filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this Mann of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 State Registrar

ian/	1 - State Registrar 1. Decedent's Name (First, Middle, L MARGARET ELI	_ast)		ertificate of L		2. Date of D	Reg. No. 2	0 2 2 ^{Year}	1322 3. Time of Death 4:10A M			
ical iner	4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town, o			4c. County					
ıl r			(In yrs, last birthda	y) If Under 1 Year Months Days	If Under 24 H Hours Mi		rth ay, Yea <i>r)</i>	9. Birthpla Country	ace (State or Foreig			
ector	Usual Residence of Decedent 10a. State 10b. County MD • BA	LTO.	10c. City, Town or	Location NOTTINGH	AM				d. Inside City Limits			
To Be Completed by Funeral Director	10e. Street and Number 8915 MAVIS AVEN	UE		10f. Zip Code 2123	6		10g. Citizen of	y?				
ed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Education Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		Specify Yes or No erto Rican, etc.)	- 14. Rad Bla Specify	ce - Americar ck, White, etc WHIT				
Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4 or 5-	(Git	cedent's Usual Occup ve kind of work done of DO NOT use retired) DMEMAKER		orking	16b. Kind of B	Business/Indu	stry			
To Be	17. Father's Name (First, Middle, Las FREDERICK S. PA	,			ne)							
	19a. Informant's Name/Relationship HERBERT J. HAEBL 20a. Method of Disposition		SE 89	15 MAVIS		NOTTING	ber, City or Town, State, Zip Code) IGHAM, MD. 21236					
	1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	ST. JOS	position (Name of rematory or other place EPH CEM •	i	Date 30-2012	20c. Location FULLER	TON, M	D.			
	21. Signature of Funeral Service Lice	ensæ		22. Name and Address9705 BEL			EK FUNER NGHAM, M		_			
ical Examiner	23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.											
b		ate of delivery	,									
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3	Ectopic pregnand	ру 		Mo	onth D	ay Year			
mpleted by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3 time of death 5	other (specify) _		1 🗆 24a. Was	tobacco use cont Yes 2 \sum No san 24b.	tribute to the 3 Probal Were autops:	<u> </u>			
Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown contributing to death bu	2 ☐ Fetal death 3 time of death 5 time of death 5 time of death 5 time of death 6 time of dea	e underlying cause give	ven in Part I. ace of Death (Cr	24a. Was auto perfi 1 \supersection Yes	tobacco use cont Yes 2 No an posy ormed? 24b.	tribute to the 3 Probal Were autops: prior to compredeath? 1 Yes 2	cause of death? bly 4 Anknowr y findings available bletion of cause of			
Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: Dive Birth 2	time of death stime o	e underlying cause give 26. Pl ient 3 □ DOA Other of 28c. Injury work	ven in Part I. ace of Death (Cree: 4 \sum Nursing	24a. Was auto perfu 1 \(\superset \) Yes seck only one) Home 5 Resi	tobacco use cont Yes 2 No an psy ormed? 24b. idence 6 Oth how injury occurr	tribute to the 3 Probal Were autops: prior to complete to complete to complete to complete to the complete to c	cause of death? bly 4 Anknowr y findings available bletion of cause of			
Certificate; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1	et in 2 ER/Outpat Year) 2 ER/Outpat Year) 28b. Time injury y - At home, farm, s (Specify) 28b. Time injury yy - At home, farm, s (specify)	26. Plient 3 DOA Other (specify) e underlying cause given and the course of the cours	ven in Part I. ace of Death (Cr er: 4 \sum Nursing y at ? Yes 2 \sum No e, date and place on, death occurre	24a. Was auto perfit of the pe	tobacco use cont Yes 2 No an 24b. psy promed? 2. No idence 6 Oth how injury occurr Street and Numb wn, State) cause(s) and maniand place, and du	were autops: prior to compideath? 1 Yes 2 er (Specify) red mer as stated, le to the cause	cause of death? bly 4 Inknowr y findings available eletion of cause of Double Number, a(s) and manner state			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deatl Apr 22, 2012 **Physician** Jane Leigh Hartig 8:57 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore Brightview Senior Living** Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F MD 216-10-7056 97 Apr 21, 1915 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show **Ellicott City** 1 ☐ Yes 2 ☑ No Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 8906 Chapel Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No If Yes. Give Specify. 9 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental P Important: If item 27 is marked old any liquy or other traumatic ever once. Be Charles Hobbs Mary Virginia Dorsey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anne Lukiewski Niece 8906 Chapel Ave Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Apr 24, 2012 Glen Burnie, MD Atlantic Crematory, LLC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** useo brovascu disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner d any, leading to in media cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exists for as a consequence of The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) the ped o 9 Unknown signed by t d be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform this certificate 2 🗆 No 1 ☐ Yes 1 🗌 Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? assisted 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann 1 V atural 28a. Date of Injury (Month, Day, Year) 28h Time of Death 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director; completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Signature and title of ce 29b State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:50 PM Patricia Hess Medical 2012 Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death DICE curity Number 9. Birthplace (State or Foreign County) nkn. Funeral 8. Date of Birth (Mosth, Day, Year) 5 Hours 1 🗆 M 2 🗀 F 216-30-2468 Director 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1X Yes 2 □ No Worchester Berlin 0 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral or items 23a 27 Hatteras Street 21811 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **5+** 12 Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Dietrich Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Neal Curley / Sister 7510 Yacht Club Drive, Berlin, MD 21811 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other? 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 4/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall) ouch Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CARRBROVASCULA disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) signed by the attending physician and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 I No 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a Was an has autopsy performed After this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence \(\text{D}\) Other (Specify) tospica 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director. Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 COAS 31. Date filed (Month, Day, 32. Register's Sign State 7 2012 Registrar

			For State Registrar	State of M	1arylan	nd / Depa		t of H	ealth		ental Hy		201	2 13232	
	Physicia		Decedent's Name (First, Middle, Frances	C •		Har	ris				2. Date of De		201 ^{Year}	3. Time of Death	
1	Medio Examir		4a. Facility Name (if not institution,	give street and number)			4b. City,	Town, or I			April	4c. (County of Deat		
	Formanal	P	512 Camelot D 5. Social Security Number		ne (In ure I	ast birthday)	If Under	Bel	Air If Under		0 Date of Di-		Harfor		
1	Funeral Director		215-22-0659 Usual Residence of Decedent	1 □ M 2 🂢 F	84		Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	Cot	hplace (State or Foreign intry) ryland	
	Maryland 28a-f sho otified at	Funeral Director	Maryland Harf	ord	10c. Cit	y, Town or Loc Bel	Air							10d, Inside City Limits 1 ☐ Yes 2X No	
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	tems tems er mu	Fune	11. Marital Status	12. Was Decedent		S. 13, V	Vas Deced			gin? (Spec	ify Yes or No- ican, etc.)		4. Race - Amer	ican Indian,	
9800	urs after d .ural", or i	þ	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No		Yes, spec				ican, etc.)		Black, White, etc. Specify: White		
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 6 years		5+)	life. Do	ent's Usua dind of wor D NOT use usewi	k done du retired)	tion <i>uring m</i> os	t of workin	g		nd of Business/I	ndustry	
	filed w al Hygid d other event, t	Be	17. Father's Name (First, Middle, La	st)	-	110	usewi		18. Moth	er's Name	(First, Middle,				
Maryland	should be file and Mental H is marked o raumatic eve	욘	Gordon Willy			1					Leash				
	and 2 shoul Health and I tem 27 is mather trauma	ï	19a. Informant's Name/Relationshi Joseph Harris	o (Type, Print) Husban	d						Route Numbe Air, M		own, State, Zip	Code) 015	
Baltimore,			20a. Method of Disposition 1X Burial 2 Cremation 4 Donation 5 Other (Sp	3 ☐ Removal from State		Place of Disposemetery, crem k Lawn	natory or or	ther place,)	Apri [®] 1 201			imore, M		
Balt	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Sept e Li	han)	Mell	762 Z2 C	Name and Onnel	Address 1y F	of Facilit uner					yland 21222	
			28a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that cause	d the death	h. Do not ente	r the mode	of dying,	, such as	cardiac or	respiratory an	est,		Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. A51	912	170	N	PR	EV.	Mo.	NA			Onset and Death.	
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ATON PNEVMONIA Squence of: ROVEWIR RECIOENT HUS squence of:									
	te be executed lysician and ne burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):				_			- 1		
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ls, P.O.	The law requires that the ate has been signed by the page 2 should be detach	ا ۾	Part II. Other significant condition	s contributing to death b	out not resu	ulting in the ur	nderlying c	ause give	n in Part I	l.				the cause of death?	
Division of Vital Records,	sician: The law req s certificate has bee lirector, page 2 sho	Completed												opsy findings available ompletion of cause of	
tal	ysician:	Be	25. Was case referred to medical examiner?	Hospital;				_		th (Check c		2 LE NO	1 🗆 165	2 🗆 110	
of Vi	g Physi er this c eral dir	e: 10	1 ☐ Yes 2 M No 27. Manner of Death	1 Inpat	ıry	ER/Outpatient 28b. Time of		Other:	4 ∐ Nu		e 5 Resid		Other (Specif	ý)	
on (ending Feath. or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion	y, Year)	injury	М	work?	es 2 🗆		a. Doddibo ii	ovv injury (occurred		
Divis	al or Att s after d al Direct ed in by		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin				et, factory,	office		28	3f. Location (S City or Tow		Number or Rura	il Route Number,	
_	To the Hospital or Attending Physician: the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check 2 L Medical Ex	Physician: To the best of aminer: On the basis of elurse Practitioner: To the	examination	and/or investi	aation, in n	noinian vo	 death oc 	curred at the	e time, date ar	nd place, a	and due to the ca	suse(s) and manner stated	
	To the Constitution		29b. Signature and title of certifier	Volar	Ro	>	29c.	License r)りゅ	number	_		29d. Date	signed (Month.		
			30. Name and address of person when PECTO C.	VALARAO	M.L	0. 17	int) 16 17	ART	OR L	o Ro				0214021047	
X.	Stat Registra	e	31. Date filed (Montif, Day, Year) APR 2 7	2012 Dun	ar's Signati	A fa	New?								
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DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>012</u> Physician/ April Haberkam Gloria Mae 12:28 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Baltimore Dundalk 1518 Leslie Road Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Months Hours 218-28-9726 Director 1 □ M 2 X F 78 January 8, 1934 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1518 Leslie Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates and Mental Hygiene.

Is marked other than "naturraumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JCP, ,

"the Page 1 and 2 sho.

"rent of Heath and In.

"If item 27 is marke,

"ther traumatic eventher traumatic eventher" ည Irma A. Sheldon William E. Cramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1124 Gypsy Lane, Towson, Maryland Cheryl Haberkam daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot April Date 28, X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2012 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Service Licenses Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, MD: 21222 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ING disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? 1 Yes 2 No After this certificate has prior to completion of cause of death? 1 ☐ Yes 2 Who within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 O Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral D Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 10007697 Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelia E. Sanchez - Cres W / 404 Fash 404 Eastern Blud, Essex, MD 31. Date filed (Month, Day, Year) State

Registrar

	Reg. No.	2 1323							
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Keitia Depas Jones 2. Date of Death Month Day April 21, 2012	3. Time of Death 1139 hrs							
	4a. Facility Name (if not institution, give street and number) Howard County General Hospital 4b. City, Town, or Location of Death Columbia Howard								
Funeral Director	Months Days Hours Min. On Foreign	thplace (State or in untry)							
eath with the Maryland items 23a or 28a-f show any ust be sotified at once.	10a. State 10b. County 10c. City, Town or Location MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What County 10g.	•							
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21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner TO Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 2th grade 2 years Paralegal Ward 5 17. Father's Name (First, Middle, Last)	Wood							
ID 212 2 should be and Menta 27 is marke matic even	Cloyzelle K. Jones 19a. Inform t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State KATHRYN Jones / Daughter 9442 Granite Hill Road Columbia								
IMOre, Pages I an nent of Hea ant: If iter or other try	20a. Method of Disposition Date Date Date								
	23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	D 21133 Approximate Interval Between Onset and Death							
Examin ed &	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical E)	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ay Year							
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f Vital Rec Physiciae: The I ar this certificate ral director, page To Be Com	25. Was case referred to medical examiner? 1. Very Yes 2 No Hospital: 1 Inpatient 2 Very ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other:								
Division of Vita nours the date of the date of the date deal or an arrest deal or arrest or a filled in by the funeral direct Certification: To Be	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								
	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rur or Town, State) 28g. Certifier (Specify) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state								
To the He within 24 To the Fu To the Fu completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon								
10	April 24, 2012 O.C.M.E. April 24, 2012 Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
State S Registrar	APR 2. 7 2012 April 1. Date filed (Month, Day, Year)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 iam APRIL Medical 12:42 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death BALTIMORE MEDICAL TOWSON BALTIMORE CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 0746 1 ☑ M 2 ☐ F **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No more 10e. Street and Number ö 10g. Citizen of What Country? Funeral items 23a 21212 Orinc 12. Was Decodent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 lohnson 19a. Informant's N lationship (Type, Prir 19b. Mailing Address (Street and Number or Department of Health ar Important: If item 27 is any injury or other trauonce. M1 3/3/3 20b. Place of Disposition (Name of semetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugha C. Greene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Intraabdominal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner concer pancreatic months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Director: After this certificate 2 1 Yes 2 1 Yes the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 [ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitionars to the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thom MD

Registrar DHMH 17 Rev 06-2011

State

Remu E.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles Street, Towsow

lowson,

D60630

4/23

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

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ln.	Spready.			_	•	•	-	_

	1 - State Registrar		Certificate of D	Death	Reg. No.	3231
Physician/	1. Decedent's Name (First, Middle	,		2. Date of Month	Death 3. Ti	me of Death
Medical	JAMES			4	25 2012 8	IO AM
Examiner	GUOD SAMARIT			Location of Death MORE	4c. County of Death	
Funeral Director		6. Sex 7. Age (In yrs. Ia 1 XM 2 🗆 F 62		If Under 24 Hrs. 8. Date of Hours Min. (Month,	Birth Jay, Year) 9. Birthplace (S Country) 8,1949 MARYLAN	
and show dat		10c. City	, Town or Location		10d. Insi	ide City Limits
Mary 28a-f	MD.	BALTO.	NOTTINGHA	M	1 [Yes 2X No
Jeath with the Maryland items 23a or 28a-f show ler must be notified at Funeral Director	10e. Street and Number 4108 LOCH LOMO		10f. Zip Code 2123		10g. Citizen of What Country?	
des des	1 Never Married 2 X Marri	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates.	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) Specify:	14. Race - American India Black, White, etc. Specify: WHITE	ın,
21215-003 idthin 72 hours a leine. r than "natural" the Medical Ex	15. Deceden (Specify only highes	t's Education at grade completed)	16a. Decedent's Usual Occupa (Give kind of work done do	tion uring most of working	16b. Kind of Business/Industry	
ld 2121 led within 7 l Hygiene. other than ent, the Me	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT use retired) DRIVE		COURIER COMPAN	1 Y
o estate To				18. Mother's Name (First, Midda EDNA SCHMI	lle, Maiden Surname)	
re, Maryla	19a. Informant's Name/Relationsh	p (Type, Print)	19b. Mailing Address (Street ar	nd Number or Rural Route Num	nber, City or Town, State, Zip Code)	
and 2 Health Health tem 2 other t	GAIL JESSOP 20a. Method of Disposition	SPOUSE ONL BI	4108 LOCH ace of Disposition (Name of	LOMOND DRIVE	NOTTINGHAM, MD. 2	
Baltimore, Ma permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau once.	1 K Burial 2 Cremation 4 Donation 5 Other (Sp	3 Removal from State ce pecify) PA	emetery, crematory or other place RKWOOD CEMETER	y 4-28-2012	20c. Location - City or Town, Sta PARKVILLE, MD. K FUNERALHOME, INC.	
Day in more	21. Signature of Funeral Service Li	í 1 0 0 x	22. Name and Address 9705 BELA		NGHAM, MD.21236	•
Physician/ Medical Examiner	shock, or neart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. SEPT Due to (or as a conseque	Do not enter the mode of dying SHOCK ence of): MDIFFICILE		Interva	kimate Il Between and Death
8760 ifficate be executed as the burial-transit Medical Examiner	Sequentially list conditions, if any, each go manufacture cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) d.	ਗ ਰ ਤ ਪਾ j ੰ			
Box 6i death cert cert he attendir ned for use		23c. If yes, outcome of pregnan 1	death 3 Ectopic pregnancy		23d. Date of delivery Month Day	Year
ds, P.O. equires that the een signed by the fould be detacl found by the feed by Physter ited by Physter is the feed by the fee	Part II. Other significant condition	S contributing to death but not result RCINOMA,	lting in the underlying cause give		d tobacco use contribute to the cause	
Records, The law requires cate has been sig ; page 2 should b				24a. Wa au pe 1 □ Ye	as an 24b. Were autopsy findi prior to completion death?	of cause of
of Vital ng Physician: ter this certific neral director, te: To Be	25. Was case referred to medical examiner?	Hospital:	l ou	ce of Death (Check only one)		
of Virginia Physic er this coneral direction	27. Manner of Death	28a. Date of injury 2	28b. Time of 28c. Injury	4 Nursing Home 5 He	e how injury occurred	
ivision of or Attending P after death. Director: After t I in by the funer: Certificate:	1 Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could n	ation of he		es 2 □ No		
Division oital or Attendir ours after death. and Director: Aff filled in by the fu	4 Homicide determin	building, etc. (Specify)	ne, farm, street, factory, office	City or To	n (Street and Number or Rural Route N Town, State)	lumber,
the Hospita thin 24 hours the Funeral ompletely filled	(Check 2 \(\sum \) Medical Ex	Physician: To the best of my knowler aminer: On the basis of examination a Jurse Practitioner: To the best of my	and/or investigation, in my opinion knowledge, death occurred at the	, death occurred at the time, date e time, date and place, and due to	e and place, and due to the cause(s) and the cause(s) and manner as stated.	
P ≥ 5 8	zab. Signature and title of certifier	13	29c. License r	000	29d. Date signed (Month, Day, Year 4/25/2012)
6 V	SUNGRYONG NOH		OCH RAVEN BIV	D, BALTIMORE	MD. 21239	
State Registrar	APR 2 7 2	12 Registrar's Signatur	faces		· · · · · · · · · · · · · · · · · · ·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

			1 - State 0 State 0 Registrar	of Maryland / Depa	artment of He rtificate of De			eg. No. 20	12 13237				
	Physicia Medic		Decedent's Name (First, Middle, Last) Mary	Ann Jackson			2. Date of Death		3. Time of Death 08:20 pm M				
,	Examin		4a. Facility Name (if not institution, give street and num Washington Adventist Hospital	nber)	4b. City, Town, or L	ocation of Death	·	4c. County of	Death Ontgomery				
5	Funeral Director		1	7. Age (In yrs. last birthday) 68 Yrs.	1	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthplace (State or Foreign Country) North Carolina				
	iryland I-f show ied at	Director	10a. State 10b. County MD Prince George's	10c. City, Town or Lo		I			10d. Inside City Limits 1X Yes 2 □ No				
	the Ma or 28a oe notif	I Dire	10e. Street and Number		10f. Zip Code	Hyattsville _	1	0g. Citizen of Wh					
	ath with ems 23a must I	Funeral	4922 Lasalle Road 11. Marital Status 12. Was Dece	dent Ever in U.S. 13.	Was Decedent of Hisr	20782	rify Yes or No-		USA American Indian,				
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-1 sho important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Widowed 4 Divorced Armed Fo 1 Yes If Yes, Giv Year or De	2/1 No e	Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2X No		Rican, etc.)		White, etc.				
Maryland 21215-0036	72 hour n "natu 1edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done dui O NOT use retired)		ng	16b. Kind of Busi					
212	I within ygiene.		Elementary/Secondary (0-12) College (1-	-4 or 5+)	Did not	work	N/A						
and	be filed ental Hy ked ott ic even	To Be	17. Father's Name (First, Middle, Last) Willie Ev	ans		18. Mother's Name		tie Evans					
lary	should and M is mar aumat		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street an		Route Number,	City or Town, Stat	re, Zip Code)				
e, S	and 2 Health tem 27 other tr		Sandra Jackson / Daughter 20a. Method of Disposition	20b. Place of Dispo	Princess Gard	D		20706 20c. Location - C	itv or Town. State				
Baltimore,	Page 1 ment of ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	otate	natory or other place) ke Crematory		2012		sville, MD				
Ball	permit Depart Impor any in	1	21. Signature of Funeral Service Licensee Dorota Marshall	/ 1 1	2. Name and Address Maryland Cren	•	es, PO Box	x 1413 Balti	more, MD 21203				
H			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ea Immediate Cause (Final	caused the death. Do not ent	er the mode of dying,				Approximate Interval Between Onset and Death				
	Medical		disease or condition	or as a consequence of):					Onset and Death				
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B	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
3760 Ag	sate be executed 'physician and sthe burial-transit	ledical E	resulting in death) Last Due to (or as a consequence of):									
6876	rtificate ling phy e as th	/Med	IF FEMALE:										
Box (To the Hospital or Attending Physician: The law requires that the death certific within 24 horurs after decreased within 24 horurs after decreased from the confidence of the attending completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	of delivery n Day Year									
ds, P.0	quires that t en signed b ould be deta	by	Part II. Other significant conditions contributing to d	eath but not resulting in the u	ınderlying cause giver	n in Part I.			ute to the cause of death?				
Division of Vital Records, P.O. Box	The law rec cate has be page 2 sho	Completed					24a. Was an autops perforn 1 Yes 2	y prio	re autopsy findings available or to completion of cause of ath? Yes 2 \sumbed No				
/ital	rsician: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 - ER/Outpatien	Other	e of Death (Check		nce 6 🗆 Other (Specific				
on of	inding Phy ath. r: After this	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury a work?			w injury occurred	ореспу)				
Divisi	tal or Atter rs after de al Directo			of Injury - At home, farm, str ng, etc. (Specify)	eet, factory, office	2	28f. Location (Str. City or Town,		or Rural Route Number,				
	he Hospi iin 24 hou he Funer ipletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base only one) 3 Certifying Nurse Practitioner	is of examination and/or inves	tigation, in my opinion,	death occurred at	the time, date and	d place, and due to	the cause(s) and manner stated.				
	To 1 To 1 Con		29b. Signature and title of certifier		29c. License n	number () 601,0		9d. Date signed (A	Month, Day, Year) 9—/2_				
	\		30. Name and address of person who completed caus 831 Unit using	BLOD Sont		wint 16	20901	w F)					
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. R	egistrars Signature	<u> </u>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>12</u> Physician/ April LaWanda S. Kight 24 11:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center for Hospice Towson Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 216 22 5432 85 Director 1 □ M 2X F 07/30/1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Baltimore Middle River 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be I Funeral 21220 7514 Biscayne Bay Blvd. United States ral", or items 2 Examiner mus Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛂 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White etc. by 1 Never Married 2 Married altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: white "natural", 3x Widowed 4 □ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) n and Mental Hygiene.
7 is marked other than raumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and ...
of Health an...
* item 27 is marn...
** traumatic ev ပ William Fisher Lancaster Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. 7514 Biscayne Bay Blvd Middle River Md 21220 Edgar K. Kight (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Maryland Veterans Cem: 4/30/2012 Crownsville, Maryland of Funeral Service Lic 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato, arrest or heart failure. Listionly one cruse on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on Exami burial-trar and that initiated events requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Dav Year g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 perform Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 힏 Other: ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Our first ying Nurse Practitioner: To the best of my knowledge, and the cause of the time, date and place are the cause of the cause o 29a. Certifier Crti ving Nurse Practitioner To the hest of my knowledge nly one) 29d. Date signed (Month, Day, Year) 821500D who completed cause of death (Item 23a) (Type, Print) *4105, Balthour, MD 21204 naheeu

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13239 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ 2012 10:20 PM April Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u> Anne Arundel</u> Severna Park Genesis Elder Care - Severna Park If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year Social Security Number Funeral Days Hours Min 1 □ M 2 XXF 71 Director 261-70-9850 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location **Funeral Director** 1 🗆 Yes 2XX No must be notified Glen Burnie MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 23a Page 1 and 2 should be filed within 72 hours after death with USA 403 West Ordnance Road #215 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2XX No Black, White, etc. 1 Never Married 2 Married þ "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. White If Yes Give Specify: 3 XXWidowed 4 ☐ Divorced Completed and Mental Hygiene.
is marked other than "naturraumatic event, the Medical F 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 12 Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Randal1 Natalie Lynn Henry Lepley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Severna Park, MD 21146 Mr. Paul Lepley / Son 300 Pine Circle injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State 4/24/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of FacilitySingleton Funeral & Cremation Funeral Se Vice Licens Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 61220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** diovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to res a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has 26. Place of Death (Check only one, 25. Was case referred to medical Be examiner? Hospital Other: 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elkridge, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kro11 Margret Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number . Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Germany Months 1 M 2 X F Hours 12/28/1931 Director 80 213-34-0153 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 🗆 Yes 2 💢 No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 308 Nicole Lane 21061 Germany 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Krutzfeldt Werner Bertha 1 and 2 should b 1 Health and Mer Lamprecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Mrs. Edith Cartzendafner 308 Nicole Lane Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 04/30/2012 Glen Burnie, MD Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD MO1479 Deleno der Singleton Funeral & Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) If any leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 morths?

1 Yes 2 No
9 Unknown Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Day be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available 24a. Was an has page 2 autopsy prior to completion of cause of death? autops, performed within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 2 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certified number 29d. Date signed (Month, Day, Year) 20 mpleted cause of death (Item 234) (Type, Print) Name and address of person who USP 112

Registrar

State

31. Date filed (Month, Day, Year)

APR 27

21061

0

4b. City, Town, or Location of Death

Rockville

^{Day} 2012

4c. County of Death

Montgomery

A M

5:00

April 18,

Physician/ Medical Examiner For State Registrar

Bernard William Keller

4a. Facility Name (if not institution, give street and number)

4308 Judith Street

Funeral Hours 069-22-5403 **Director** 1 X M 2 □ F 82 May 2, 1929 28a-f show with the Maryland at Director 10a. State 10b. Count 10c. City, Town or Location notified Maryland Rockville Montgomery ō 10e. Street and Number 10f. Zip Code items 23a or ner must be r Funeral 4308 Judith Street 20853 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1946—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 0 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 X No Specify "natural" 3 Widowed 4 Divorced Completed 1948 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Deputy Director other Be 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ္ Frederick Ammon Keller 19a. Informant's Name/Relationship (Type, Print) Patsy K. Keller/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Unllin M01173 (w 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ Liver Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cryptogenic Cirrhosis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Ischemic Heart Disease 24a. Was an has performed this certificate Yes 2 X No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: After t 28c, Injury at X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be s after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D31839 April 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Dunford, M.D. 615 W. Montgomery Avenue, Rockville, Maryland 20850 31. Date filed (Month, Day, Year, 32. Registrar's Signatu State

5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Days New York 10d. Inside City Limits 1 ☐ Yes 2 🛣 No 10g. Citizen of What Country? United States 14. Race - American Indian. Black White etc. White 16b. Kind of Business/Industry Police Communications Montgomery County 18. Mother's Name (First, Middle, Maiden Surname) Elena Maude Pierce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4308 Judith Street, Rockville, Maryland 20c. Location - City or Town, State Bethesda, Maryland Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Approximate Interval Between Two months 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 X Residence 6 Other (Specify) 28d. Describe how injury occurred

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g928 6-19-12 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ Month 4:50 A M April ANNA MAE KRESS 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Hours JULY 16.1929 MARYLAND Yrs Director 213-26-1940 82 Usual Residence of Decedent or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director MD. BALTIMORE 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4804 ARABIA AVENUE 21214 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, . Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 XNo Specify: Specify: Completed 3 ₩ Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10TH CLOTHING STORE SALES CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ HARRY MAISEL LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 4804 ARABIA AVENUE BALTO.MD. 21214 LINDA GERLACH 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **UNK** Date Department of H Important: If ite any injury or ot once, cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 4-30-12 TLANTIC CREMATORY 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR ROAD BALTO.MD. 21206 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final ₽nysician/ disease or condition resulting in death) Vocardia day Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsy this certificate has performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 1 ☐ Yes 2 ☑ No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work?
1 Yes 2 No injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

(Check only one) 29b. Signature and title of certi

Lai 31. Date filed (Month, Day, Year) MD

Memorial Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AT2438946

201 E. University Pkwy, Baltimore MD

29d. Date signed (Month. Day, Year)

April 19 2012

21218

			For State		State o	f Marylan					and M	lental Hy	/giene	0.0.1	0 1001
			Registrar 1. Decedent's Name	e (First, Middle, L	ast)		Cer	tificate	of L	eath	Т	2. Date of De	Reg. No.	201	2 324
	Physicia Medio		BETTY	, , , , , , , , , , , , , , , , , , , ,	,	KLEEM	AN					Apri (Day 25	Year 20/2	3. Time of Death 2:58 A M
	Examin		4a. Facility Name (if Sinai He	not institution, gi	ve street and num	ber)		4b. City, T				, 4,,,		County of Dea	
and a	Funeral		5. Social Security No		J	7. Age (In yrs. Ia		If Under	1 Year	Mora If Under		8. Date of Bir	rth	N/A	rthplace (State or Foreign
	Director		217-16-		1 □ M 2 🛣 F	94	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)	Co	GERMANY
and	show	'n	Usual Residence of 10a. State	10b. County			y, Town or Loc	ation				02/09	7 1 9 1 0	<u>'</u>	10d. Inside City Limits
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eath w	tems 2 er mus	Funeral Director	11. Marital Status	KIUM COL	RT, APT.	dent Ever in U.S	S. 13. W	as Decede		1117 Spanic Orio	in? (Spec	cify Yes or No- Rican, etc.)	1	USA 4. Race - Ame	erican Indian
36 after d	", or it		1 Never Marri		Armed For 1 Yes If Yes, Give	ces? 2 X No		Yes, specif			, Puerto F	Rican, etc.)		Black, Whit	
21215-0036 within 72 hours after death with the Maryland	ical Ex	Completed by	3 XWidowed	15. Decedent's	Year or Date		16a. Deced							pecify:	WHITE
215 215 12 Til	han "r e Med	omp	(Spec	cify only highest o	grade completed) College (1-	4 or 5+)	(Give k	ind of work NOT use r	done di		of workin	g	IOD. KIN	d of Business	Andustry
nd 21	Hygier other t	l as l	12 17. Father's Name (F	irst Middle Last	1		HOM	EMAKE		40.11.11				OWN HO	ME
Maryland 21215-0036	fental	욘	SIGMUND	not, whole, zadi	,	GII	DEON				rs Name THA	(First, Middle,	Maiden St		CHWARTZ
Aary should	and N is ma auma		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailing	Address (Street a			Route Numbe	er, City or To	own, State, Zi	
and 2 s	Health tem 27 ther to		HOWARD]	KLEEMAN/	SON	20h B	2240 Place of Dispos			POINT					S, IL 60004
Be#4 timore, N	nt: If if		1 🗓 Burial 2		Removal from s	State C	emetery, crem	atory or oth	er place			/2012		ation - City or	TOWN, State
Baltimore	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Fun			Jones		Name and							S., INC.
L			23a. Part 1. Enter th	9 (ILLE,	MD 21208
- Phy	skolan)		snock, or near Immediate Cause (F	t failure. List only Final	one cause on eac	ch line.					ardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
() N	/ledical		disease or condition resulting in death)	•	Due to (c	or as a consequ		<i>C</i> 0	7 7 0	ae_					oneday
EX	aminer	er	Sequentially list con	nditions,	b. —	psis	7								one day
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A company	ia iii	al Ex	that initiated events resulting in death) L	ast	C. Due to (c	Due to (or as a consequence of):									
760 cate be	hysic the b	edical			d		<u> </u>						-		<u> </u>
certific	been signed by the attending p should be detached for use as		IF FEMALE: 23b. Was decedent p		23c. If yes, outc	ome of pregnar	ncy						23	3d. Date of de	liverv
Box death	he atte	/sicia	in the past 12 m 1 Pes 2 F 9 Unknown	nonths? K No	4 Pregn	Sirth 2 Feta ant at time of d	leath $3 \square$	Other (spec	egnancy cify)		·			Month	Day Year
o.			Part II. Other signific	cant conditions			ulting in the un	derlying ca	use give	en in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
ds, F	an sign	Completed by	urina	iry trac	t infe	ction									robably 4 🗆 Unknown
COTC aw req	as bee	nplet										24a. Was		24b. Were au	topsy findings available completion of cause of
Re The	s certificate has b director, page 2 s		25. Was case referre	al to one die of									rmed?	death?	3 2 □ No
Vita ysiciar	s certif directo	To Be	examiner?		Hospital:	npatient 2 🗆 I	EP/Outpationt	3 🗆 DOM	Othor	e of Death				C oul 70	hospice
of of Physics	fter thi		27. Manner of Death	5 Pending	28a. Date of		28b. Time of injury		. Injury : work?	at		e 5 🗀 Resid Bd. Describe h		✓Other (Spec occurred	ity)
sion ttendi	y the fu	Certificate:	2 Accident 3 Suicide	Investigation	he -	of latinate At have		M	1 🗆 Y	es 2 🗍 l					
Division of Vital Records, P.O. Box 687 alor attending Physician: The law requires that the death certifics after cleath.	al Direction by		4 L Homicide	determined	building	of Injury - At hor g, etc. <i>(Specify)</i>	me, rarm, stree	t, factory, c	OTTICE		28	3f. Location (S City or Tow	Street and f n, State)	Number or Rui	al Route Number,
Hospit 4	To the Fundant Director: After this certific completely filled in by the funeral director,	0			ysician: To the bearinger: On the basis										
To the I	To the Complex	ž	only one) 3 [29b. Signature and the	Certifying Nu	rse Practitioner:	To the best of m	y knowledge, o	leath occur	ed at the	time, date	and place	e, and due to t	he cause(s)	and manner a	s stated.
			136	_	MI	D		2	70	334			April	25	, 20/2
	12		only one) 3 29b. Signature and the second of	ss of person who	completed cause	of death (Item	23a) (Type, Pri	fr; mo	e.	240/	w.B	elvede	reA	ve Ba	letmore
	State	e	31. Date filed (Month,	Day, Year)	32. F	gistrar's Signatu	ure	- 41						mo 2	1215
	Registra	014		APR 27	2012	war ,	B. A	ut		 :					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Physician/ Month 1933 Orot Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗹 F Min. 9 Hours Yrs. Director MARKY ms 23a or 28a-f show must be notified at . State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. "natural", 3 Widowed 4 ☐ Divorced Completed A merican Indied Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical Jonce. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-A or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) o Funeral Service Licensee 21. Signat Name and Address of 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Athenselansis Onset and Death Physician/ Coronary arten disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of). flary, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery Month Day Year signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be Diabetes 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown typenteusion Chronic obstructive perhuonary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 R/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at other death of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and out to the cause(s) and manner at other death of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and out to the cause(s) and manner at other death occurred at the time, date and place and out the cause(s) and manner at the time. (Check within 2 To the I 29c. License number D0068107 13,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 900 South Caton Avenue

State Registrar 32. Registrar's Signat

Onier Villameal Alejautro, MD

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 Physician/ 20^{Year} P^{M} Barry Irwin Lipov 1:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 01ney 18020 Overwood Drive Montgomery If Under 24 Hrs Hours Min. 5. Social Security Number If Under 1 Year Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Davs (Month, Day, Year) Director 577-48-7886 1 💢 M 2 🗆 F 75 Washington, DC Usual Residence of Decedent 3-27-1937 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director be notified 01ney 1 X Yes 2 □ No MD Montgomery or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Examiner must 20832 United States 18020 Overwood Drive items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. or o X Yes 2 No 1955 If Yes, Give 1962 Black, White, etc. 2 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 1962 1 ☐ Yes 2 X No Specify "natural", White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Water Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stella Orloff Hyman Lipov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18020 Overwood Drive, Olney, Maryland 20832 Rose Halle Lipov - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State King David Mem. Park 4-19-2012 4 Donation 5 Other (Specify) Falls Church, Virginia of Fineral Service Licenses 22. Name and Address of Facility Kurt Blake Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 M01477 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Liver Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE. use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Year Month Pregnant at time of death Day 2 No detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by COPD 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 24 No certificate has 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **X** No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 N Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work?
1 Yes 2 No after death. М Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

201

State

DHMH 17 Rev 06-2011

29b. Signature and title

Shashank Patel,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

18121 Georgia Avenue, #103, Olney, Maryland 20832

D58962

29d. Date signed (Month, Day, Year) 4-16-2012

			1 - State of Maryland / Dep	partment of Health and ertificate of Death	, ,	liene	2 13246			
	Physicia		Decedent's Name (First, Middle, Last) Lillian Lancey		2. Date of Dear	th	3. Time of Death 12 12:20 P M			
	Medio Examir		4a. Facility Name (if not institution, give street and number) The Grove	4b. City, Town, or Location of Death Kensington)	4c. County of Do	eath			
	Funeral Director		5. Social Security Number 128-16-0283 Usual Residence of Decedent 6. Sex 1 M 2 TF 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 6-3-19	Year)	Birthplace (State or Foreign Country) EW York			
	e Maryland r 28a-f sho notified at	Director	NY Suffolk Dix Hill 10e. Street and Number				10d. Inside City Limits 1 🛣 Yes 2 □ No			
	h with th	Funeral I	49 Randolph Drive	10f. Zip Code 11746	J	Og. Citizen of What United Sta	*			
9800	within 72 hours after death with the Maryland glene. glene then "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3X □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces 2 1 □ ∨ s 2 ☑ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛛 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify:	nerican Indian, nite, etc. White			
Maryland 21215-0036	e filed within 72 hours after death with the Mayland tall Hygiene. It was tall Hygiene at them "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	e Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homen	edent's Usual Occupation kind of work done during most of work DO NOT use retired) naker	king	16b. Kind of Business/Industry Own Home				
yland	should be filed or and Mental Hyg 7 is marked other raumatic event.	To Be	17. Father's Name (First, Middle, Last) Sam Potashnick	18. Mother's Name (First, Middle, Maiden Surname) Frieda Freidman						
	of Health and Ment of Health and Ment fitem 27 is marked rother traumatic		Paul Lancey - Son 49 H	ing Address (Street and Number or Run Randolph Drive, Di	x Hill,	New York	11746			
Baltimore,	t. Page tment tant: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) We11wood	matory or other place) Cemetery 4-22		20c. Location - City Farmingda	or Town, State le, New York			
Ba	Depar Impol any ir		M01477 1	170 Rockville Pik	e, Rockv					
	hyuician/ Medical		Immediate Cause (Final disease or condition resulting in death). Arteriolosclerotic resulting in death).	Arteriolosclerotic Heart Disease						
	Examiner	er	Due to (or as a consequence of): Sequentially list conditions, If any, leading to minimidate Due to (or as a consequence of): Congestive Heart Due to (or as a consequence of):							
	te be executed hysician and he burial-transit	Examir	If any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Type II Due to (or as a consequence of):							
092	cate be e physiciar s the buri	edical	d. Hypertension							
). Box 68760	ne law requires that the death certificat ate has been signed by the attending ph page 2 should be detached for use as the			Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year			
rds, P.C	s the	ا ۾	Part II. Other significant conditions contributing to death but not resulting in the Dementia	underlying cause given in Part I.			to the cause of death?			
Division of Vital Records, P.O.	Ine law ate has page 2	e Completed	25. Was case referred to medical	00.00	24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of es 2 No			
F Vita	rnysician: I this certifica eral director, p	10 B	examiner? Hospital: I patient 2 FR/Outpatie	26. Place of Death (Check ont 3 DOA Other: 4 X Nursing Ho		nce 6 Other (Spe	cify)			
sion o	or en Cospinal or Attending Priysician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certificate:	27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be determined determined	work? M 1 Yes 2 No	28f Location (Str	injury occurred	uml Pauta Number			
Σ Ω	spital or spital or nours afte neral Dire		building, etc. (Specify) 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge death	occurred at the time, date and place, a	City or Town,	State)	stated			
	vithin 24 To the Fu	Medical	(Check 2 ☐ Medical Examiner on the basis of examination and/or investigning only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	fidation in my opinion, death occurred of	the time, date and ace, and due to the	place and due to the	cause(s) and manner stated. as stated.			
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D53691		April 19,	2012			
13	} \ \			d., #110, Rockvil	le, Mary	land 2085	2			
. , , , ,	State Registra	_		entel						

DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 13247 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Patricia Dwight Lawrence 0908 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Ye 1 ☐ M 2🏋 F Months Hours Min. Washington, 83 262-34-7269 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location notified at Director 1 X Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 20850 United States 14431 Traville Garden Circle #416 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 11. Marital Status Bace - American Indian. Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ŏ ģ be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Secretary Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kate Mushinsky Paul Dwight Weeks 20850 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14431 Traville Garden Circle #416 Rockville, MD Walter Lawrence - Husband Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden Of Remembrance 4-24-2012 Clarksburg, MD Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kurt Blake 1091 Rockville Pike, Rockville, Maryland 20852 M01477 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myo Cardial minutes disease or condition Medical resulting in death) **Examiner** coronary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ∐ Fetal dea ☐ Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Other (specify) signed by the a g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 🗌 Yes 2 No 3 Probably 4 X Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 🗷 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 X ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending iniury 1 Matural 24 hours after death. Funeral Director: At Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6
Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the F the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

DV

0

awrence,

9901

Medical Center Drive Rockville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wenk

MD

onathon

31. Date filed (Month, Day, Year)

2012

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 2:10 Celia Lillian Lachter Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Manorcare Potomac 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye. 7-7-193] 1 M 2 XF Months Days Hours Min. 80 **Director** 104-28-7380 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville 1 Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 13823 Goosefoot Terrace death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married ğ 2 X No Yes Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Bondar Max Steinman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 13823 Goosefoot Terrace, Rockville, Maryland 20850 Louis Lachter - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Mt. Lebanon Cem. 4-24-2012 New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kurt Blake 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 M01477 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ _{a.}Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atherosclerotic Vascular Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ending physician or use as the burial Physician/Medical that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Year Pregnant at time of death Other (specify) the detached 9 Unknown Unknown P.O. sate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law thin 24 hours after death.

The Funeral Director: After this certificate has be autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 \square Residence 6 \square Other (Specify 2X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

5 V

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Thomas Masterson, MD

31. Date filed (Month, Day, Year) APR 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D50534

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

- 6858 old Dominion Dr., #104, Mclean Virginia 22101

29d. Date signed (Month, Day, Year)

4-22-12

Robert J. Lamm		1- For State	ate of Marylan	_	artment of rtificate of		Mental H	_	eg No. 21	012	1324
Physici		Registrar 1. Decedent's Name (First, Midd	le,Last)					2. Date of Dea	ath	3. Tim	ne of Death
Medical Exami	ner	Robert J		Sr.				Month April 21, 2	Day Year 2012	18	36 hrs
		4a. Facility Name (if not institution Baltimore Washington		er)	4	4b. City, Town, or L Glen Burnie	ocation of Death		4c. County o		
Funeral		Social Security Number		Age (In vrs. I	last birthday)	If Under 1 Year	If Under 24Hrs	8 Date of Bi	rth(MM/DD/YYYY)		(State or
Director		218-44-2088	1XM 2F		-	Months Days	Hours Min.	-	,	Foreign Country)	
_		Usual Residence of Decedent	1 A W 2 1		67 Yrs.	<u> </u>		04/0	5/1945		MD
r any		10a. State 10b. County		10c. City	, Town or Locati	on					nside City Limits
Maryland 28a-f show	ō		Arundel			Glen Bu	rnie				Yes 2 X No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number	_			10f. Zip Code		1	10g. Citizen of Wha		
72 hours after death with the Maryland o "natural", or items 23a or 28a-f sho al Examiner must be notified at once		7821 Overhill I	Road 12. Was Decede	ant Ever in II	C 112 Ma	2 s Decedent of Hisp	1060	anifu Voc or No	14 Bees	USA - American Ind	fon Block
eath w	Funeral	1 Never Married 2 X M	arried Armed Force	es?		es, specify Cuban,			White,		IIdii, Diach,
ufter d	by Fu	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	2 X No	1	Yes 2 No	specify:		Specify:	White	9
hours a		15. Decedent's Education (Spe	cify only highest grade of			t's Usual Occupationst of working life.			16b. Kind of Bus	iness/Industry	/
36 in 72 l	plet	Elementary/Secondary (0-12)	College (1-4 o	or 5+)					M	- 3 OL - 1	
5-0036 led within 72 Hygiene. other that	Completed	17. Father's Name (First, Middle	, Last)			Caretak		(First, Middle,	Marylar Maiden Surname)	ia stat	<u>te</u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other thao	Be	Earl Woodro	w Lamm				Blanche	e Wh	ishman		
hould hould is man	٩	19a. Informant's Name/Relations							mber, City or Town		
e, MD 2 I and 2 shou Health and N item 27 is n		Frances M. Lami 20a. Method of Disposition	ıı (sp	ouse)		tion (Name of cem			urnie, M		
2 5 5 5 5 1	- 1	1 X Burial 2 Cremation		State	crematory or oth		Apı	rff 25 2012			
Baltimo permit. Pages Department o Important:	-	4 Donation 5 Other Sp 21. Signature of Fune al Service	pecify:	GIE		ame and Address	. C. E T. L.				Maryland
Den		142	7					Stalling Road, Pa	gs Funera asadena,	a⊥ Home MD 211	P.A.
Physician		23a. Part I. Enter the disease of failure. List only one cause	complications that caus	ed the death	. Do not enter th	ne mode of dying, s	such as cardiac or	r respiratory arr	rest, shock, or hea	rt Appr	roximate Interval
/Medical Examiner	1	Immediate Cause (Mnal disease	a Hyperten			clerotic	Cardiov	ascular	Disease		Death
		or condition resulting in death)	Due to (or as a co	nsequence o	of):						
	ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence o	of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence o	if):						
executed an and al - transit	EX	events resulting in death) Last	d		,						
	dical	X UNPENDED	AMENDED 23	a,pt.]	[1,27,pe	er me,g92	7 5-2-12	2 sm			
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outo			2 [7e		23d. Date of c	•	
x 68 h certif	ciar	past 12 months?	4 Pregnant	at time of	- =	al death 3 L ner (Specify)	Ectopic pregna	ncy	Month	Day	Year
BO) e deatl the att	hysi		known 9 death Unknown								
P.O. BC that the des	by P	Part II. Other significant condit							obacco use contrib		se of death?
Division of Vital Records, P.O. fal or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ted	Chronic Obst	ructive Pul	monary	y Diseas	se;Diabet	es Mellit	24a. Was			ndings available
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Vital Reconysician: The law this certificate has I director, page 2 s		25 Was seen seferand to madica				Of Disease	of Death (Obselve	1 ✔ Yes		✓ Yes	2 No
Vital ysician: his certif director,	Be	25. Was case referred to medica examiner?	11	ntient 2	ER/Outpatient		of Death (Check of Death (Chec	, ,	Residence 6	Other:	
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IVIS or At after d Direct	Certification	3 Suicide 6 Coul	d not be 28e. Place of	Injury - At he	ome, farm, stree	t, factory, office bu	ilding, etc.	28f. Location (S	Street and Number	or Rural Rout	te Number, City
DIVI Divi Sepital or hours after meral Dir y filled in	S	4 Homicide	rmined (Specify)	_							<u> </u>
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(Check only Certifying Pi	nysician: To the best of miner: On the basis of ex	xamination a							e(s)
To vit	Mec	29b. Signature and title of certifie	and manner state	ed.	/	29c. License	number		29d. Date signed	d (Month, Day	, Year)
		1/11/16		/	DO	O.C.M	l.E.		April 22, 20	12	
		30 Name and ad ess of person							<u> </u>		
		Russell Alexander MD				N. Baltimore S	Street, Baltim	ore, MD 21	223		L
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	trar's Signatu	are backet						
		ANN Z / CUIC	- Laboration	- 10 · 16	PALSA.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:000 Physician/ LYLES III **EVERETT** Α. 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Director 577-80-9889 1 **X** M 2 □ F NOV. 8 1957 WASHINGTON, DC 54 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1X Yes 2 No PRINCE GEORGE'S BOWIE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be 23a Funeral 20720 USA 7906 QUINTA COURT items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White etc. BLACK Armed Forces? 0 by 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE NETWORK ADMIN. of Health and Mental Hygitem 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ BARBARA KING pe EVERETT LYLES JR. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Page 1 and 2 sh De, artment of Health an Important: If item 27 is any injury or other trau 7906 QUINTA COURT BOWIE, MARYLAND 20720 BARBARA KING LYLES/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State RIVERDALE RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 4/30/2012 CREMATORY Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Naphne 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the dise st., or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events the burial-trar attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical ivision of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death , the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown or Attending Physician: The law requires page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 No 1 Tyes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes Certificate: To A/Outpatient 3 DOA 1 Inpatient 2 1 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work?
1 \(\sum \) Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) who completed caus and address of person of de h (Item Name ROAD Good Luck lector mi 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

			For State	State of	f Marylan		artment of		and M	lental Hy	giene	2013	2 1325		
			Registrar 1. Decedent's Name (First, Middle	1 act)	Certificate of Death					Reg. No. 2012 1325					
	Physicia			mes Richard Loane,			Jr.			Month Day Yea		Year	1:39 A ^M		
	Medic Examin		4a. Facility Name (if not institution,				4b. City. Town, or Location of Death			April	ril 26, 2012 1:39				
كاعتد	Examin		Gilchrist Hos	nice Cente	r		л	lowson					Ltimore		
	Funeral		5. Social Security Number		7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Day	ar If Under	24 Hrs. Min.	8. Date of Birt (Month, Day		9. Bir	thplace (State or Foreign untry)		
	Director		218-14-9973	1 🔀 M 2 🗆 F	87	Yrs.	WORLINS Day	s Hours		Nov. 7,			Maryland		
	now at	Ļ	Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Loc	ation			1100. 7,	1221		10d. Inside City Limits		
	arylan a-f sh fled a	Director					Baltimore						1 ☐ Yes 2 🔀 No		
	or 28		Maryland Ba. 10e. Street and Number		10f. Zip Code				10a, Citizer	of What Co					
	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	eral	1221 Hilldale	Road				21237	,		United	States	of America		
		Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S	3. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Orig	gin? (Spe	cify Yes or No-	14.		rican Indian,		
ð	fter d , or i amin	ò	1 Never Married 2 X Marr	ried Armed Formula 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 No		Yes 2 🔏		nican, etc.)	S.n.	Black, White, etc. Specify: White				
Š	ours a tural' al Ex	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.												
င်	72 hc n "na ledic	nple	(Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)				ng		Kind of Business/Industry Imbers and Steam Fitters			
717	within 72 /giene. ner than '	Co	Elementary/Secondary (0-12) College (1-4 or 5+)				Plumber						- Union 46		
0	age 1 and 2 should be filed went of Health and Mental Hygi t: If item 27 is marked othe y or other traumatic event,	Be	17. Father's Name (First, Middle, L	.ast)			2 2 01.00		er's Name	e (First, Middle,	Maiden Sun	name)			
Maryland 21215-0036		မ	James Richard Loane				Alice :				. Frederick				
ar)		n 6	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Stre	et and Numbe	er or Rura	l Route Numbe	r, City or Tov	vn, State, Zij	o Code)		
			Irene V. Loane	- Spouse			Hilldal	e Road	l, Ba	ltimore					
ore	ge 1 a t of H If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from	State 20b. P	Place of Dispo emetery, cren	sition (Name of natory or other p	lace)		Date			Town, State		
Baltimore,	t. Pag tment tant: tant:		4 Donation 5 Other (S	Specify)	Gai		natory or other pot Faith Pry						Maryland		
Ra	permit, Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service L	icensee	1.1	22 I	Name and Add	iress of Facilit Ineral C	hapel	and Crem	mation	Servi	ces-Parkville		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										Approximate		
ı.	and the same	, ,	shock, or heart failure. List of Immediate Cause (Final						Interval Between Onset and Death						
	Physician/ Medical		disease or condition resulting in death)	a. Due to (c	or as a consequ	Jence of):	W					-			
	Examiner			Poe	Prosteti Caucar										
		iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Janice of):	nice off										
	executed an and rial-transi	xam	Cause (Disease or injury that initiated events												
	be exer	dical Examiner	resulting in death) Last	uence of):											
9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edic		d											
β	ertific iding ise as	Ž	IF FEMALE: 23b. Was decedent pregnant	come of pregna						230	d. Date of de	livery			
POX	atter after if for u	iciai	in the past 12 months?							Month Day Year					
о. В	the de sy the ached	Physician/Me	9 Unknown	9 ∐ Unkn	9 Unknown										
J.	that ned be det	by P	236. Did tobacco use con-												
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S	aw recast be	Completed								24a. Was an autopsy findings availal prior to completion of cause			topsy findings available completion of cause of		
ĕ	The large has page	Con	performed									s 2 🗆 No			
ta	clan: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Dea	th (Check	only one)					
<u> </u>	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours atti-death. within 24 hours atti-death. completely filled in by the funeral director, page 2 should be detached for use as the	2	1 Yes 2 No 27. Manner of Death	28a. Date o	-	ent 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other 28b. Time of 28c. Injury at 28d. Describe how injury occurre							city) Hospice		
0		cate	1 Natural 5 Pendir 2 Accident Investi	ng (Mont	h, Day, Year)	injury	W	ork?		zoa. Describe i	iow injury oc	curred	•		
Division of Vital Records,		Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	t be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location 28f.						on (Street and Number or Rural Route Number,				
5			4 El Hollinoide determ	buildir	building, etc. (Specify) City or Town, State)										
_	ospit hour unera	ledical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	the H hin 24 the F Tplet	Me	only one) 3 Certifying	Nurse Practitioner:			death occurred	at the time, da			the cause(s)	and manner a	as stated.		
	5 wit		29b. Signature and title of ertifier	// //	MA			nse number					h, Day, Year)		
J	,		and the second			000 0	D T	2139			uber	06	-2012		
0	XIV		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED Q. ABBAS MD 6701 N Charles St. Suli 4105 Ballimore MD 21204 31. Date file print 2007 2011 2 (1204) 32. Registrar & Signatural Control of the control of t												
	Stat	e	31. Date file of onto Day, 701	32. Re	egistrar Signa	back	1								
	Registra		ALIN & 1 ZOI	- rest	1. 1	7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 00 AM om Medical racility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ealth 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛂 🗗 Days Min. (Month, Day, Months Hours Country) 214-26-880 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director 1 ☐ Yes 2 ☐ No 28a-f undalk Baltimor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 2122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 1 and 2 should be filed w of Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ShiNe Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bradley-Askton 22. Name and Address of Facility Signature of E Neral 11000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause op each line Interval Between Immediate Cause (Final provasa Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 4Cas Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a const quence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last to the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2-No 3 ☐ Probably 4 ☐ Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 2 1 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 🗌 No death. Accident Accident Investigation within 24 hours after deati To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 📃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥

State

State Registrar 30. Name and address of person v

31. Date filed (Month, Day, Year)

APR 27

ho completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month Lowery Alice W. 21 April 7:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Days (Month, Day, Year) Hours Min Director 220-12-2576 1 □ M 2 🛛 F April 29, 1925 Maryland 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 404 Grandin Avenue 20850 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 **X**No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever ပ Daniel Raymond Weddle Elsie Matheny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockville, Maryland 20850 404 Grandin Avenue, Patricia A. Ruben / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemeter, crematory or other place)
Montgomery
Crematorium, Inc. 1 \square Burial 2 $\raisebox{.5ex}{$X$}$ Cremation 3 \square Removal from State April 26, 2012 Bethesda, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robert AA. Pumphrey Funeral Home/Rockville, Inc. the this M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 38 attending plant lifer use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Veal Month Yes 2 X No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💢 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗓 No 1 🗌 Yes ER/Outpatient 3 DOA မ 1 Inpatient 2 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After XNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death Accident M Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number teven April 22, 2012 MD D0063195

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Wilks, M.D.

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT E. LEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month Day Year) MARYLAND 218-14-9675 Director 1 XM 2 D F 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits aţ Director MD notified BALTIMORE 1 X Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be i Funeral 3939 ROLAND AVENUE 21211 USA 2 should be filed within 72 mount.
th and Mental Hygiene.
27 is marked other than "natural", or items items 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify WHITE Specify 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9TH MECHANIC AUTO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN LEE THELMA MCCAFFERTY other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is u JAMES LEE SON 62 PARK HILL PLACE PERRY HALL, MD. 21128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 4-26-2012 OWINGS MILL, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELATE ROAD NOTTINGHAM, MD 21236 Rand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician) YDGACO disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Live Signature of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performe certificate 1 Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation completely filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature ap 29d. Date signed (Month, Day, Year) WID DANIEL 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) ark way MD.

Registrar DHMH 17 Rev 06-2011

State

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Day 2012 23, 4:45 A. M William Lomax Lambdin Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Oak Crest Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs, last birthday) **Funeral** Maryland Maryland Days Hours Oct. 8, 1920 Min 1**X** M 2 □ F Director 91 218-05-2070 Usual Residence of Decedent and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show
is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 🗌 Yes 2 🔀 No Baltimore Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21234 8800 Walther Blvd., Apt. 4306 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Park Manager Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Edna Howeth Harrison ည William Lomax Lambdin Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1015 Leeswood Road, Bel Air, Maryland, 21014 Health tem 27 Ann M. Drummey/ Daughter Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any injury or otl once, 1 Burial 2 Kremation 3 Removal from State Bel Air, Maryland Rose Hill Svcs. LLC 4-27-2012 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 essee divenuel 23a. Eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final due to Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year 1 L Yes 2 L 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Records, DE MENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28f. Locatio (Street and Number or Rural Route Number, City or Town, State) work? 1
Natural 5 Pending 1 Yes 2 No -24-2012 2 Accident 3 Suicide Investigation his sorm after death 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

Registrar

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WALTHOR BIVD PARKVIllo, MD Z1234

4-23-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc, 10f,19b per fb,131 per dyr,4-27-12 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lawrence, Michael Littman Physician/ APCI 12:34 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4312 SONGSMITH LANE ELLICOTT CITY HOWARD Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth If Under 2 9. Birthplace (State or Foreign Funeral Months Min. (Month, Day, Year) Country **Director** 067-40-2866 1 XM 2 □ F Yrs 57 01/29/1955 NY Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director 1 Yes 2X No MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 4312 SONGSMITH LANE USA 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE nd Mental நதுக்க s marked other than "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other traumatic event, the COMPUTER PROGRAMMER DEPARTMENT OF DEFENSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 NATHAN LITTMAN HELEN PERKINS ANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 item 27 FELICIA LITTMAN/WIFE 4312 SONGSMITH LANE, ELLICOTT 20b. Place of Disposition (Name of cemetery, crematory or other place)
ETERNAL LIGHT
MEMORIAL GARDENS 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BOYNTON BEACH, FL 04/26/2012 21. Signatura 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physiciani DOVOIP disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by teo Sarcoma 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of autors death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 M No Hospital ္ဝ 1 Inpatient 2 ER/Outpatient 3 ID DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After work? 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier D0065430 oss of person who completed cause of death (Item 23a) (Type, Print) Tuliana Keta Selaru Dorsey Hall Drive, Ellicoff City, 2/042 Q Dorse 4201 32. Registrar's Signature 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LOUIS, LOVERDE Dav Physician/ Month Year 2-02 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Hospital Vorth West Baltimore Randalletow Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 213-14-9388 **Director** 1 XM 2 □ F 90 Yrs Jan. 1,1922 Maryland 28a-f show items 23a or 28a-f sho her must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1124 Linden Ave. 21227 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces
1 XYes 2 If Yes, Give
Year or Dates. Black, White, etc 9 þ 1 Never Married 2 Married 2 NO Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify. "natural", 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Roofer/ Siding Contractor and Mental Hygie is marked other Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or cert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosina Romano Joseph Loverde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 26 Pepperdine Circle, Catonsville, Maryland 21228 Joseph Loverde / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery Apr. 25, 2012 Woodlawn, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Fa AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ meumonia Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autops\ death? 1 ☐ Yes 2 🛣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X** No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical

29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anitha 31. Date filed (Month State Registrar M DHMH 17 Rev 06-2011

29a. Certifier (Check

Court

HD

5401

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D67325

April, 20,2012

Road, Randallstown, MD,21133

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

12-03007 Lolita D. Lee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012		3	2	5	8
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onta D. Lee		1- For State Certificate of De Registrar			j. No.					
Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death Month April 17, 20		3. Time of Death 1045 hrs				
Medical Examir	ier		city, Town, or Location of Death		4c. County of Deatl					
			altímore		10					
Funeral		I I	Under 1 Year If Under 24Hrs fonths Days Hours Min		Forei					
Director		216-84-4205 1 M 2 XF 40 Yrs.	Saye Medic Man	02/02/1	1972 was	SMYngton, DC				
an y	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d, Inside City Limits				
E .,	٦	MD n/a	Baltimore			1 X Yes 2 No				
Maryla 28a-f d at o	Director		f. Zip Code		g. Citizen of What Cou	ntry?				
th the]		2920 Walbrook Avenue	21216		JSA	Sec. 1				
death with the Maryland or items 23a or 28a-f sho must be notified at ooce	Funeral		cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puerto		White, etc.	ican Indian, Black,				
ufter de	SpecifBlack									
163. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Social Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										
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15-003 filed withi Hygiene. d other th	aiden Surname)	/grene								
21215-0036 und be filed within 7 Mental Hygiene. marked other than	es									
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TOF	١	1 Burial 2 Cremation 3 Removal from State crematory or other p 4 Donation 5 Other Specify: On-Site Cre		27.2012	Baltimore	, MD				
Altic rmit. I spartm uporta	Ì	21 Sign to e of Funeral Soprice Licensee 22 Name	and Address of Facility F	uneral_D	irectors,	P.A.				
	-	23a. Rand I. Ehter the disease, or complications that caused the death. Do not enter the m	Park Heights	Ave Balt	imore, MD	21215 Approximate Interval				
Physician Wedical	- [fillure. List only one cause on each line.		or respiratory arres	it, orlock, or nour	Between Onset and Death				
Examiner	-	Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death)	cular Disease							
	اۃ	Sequentially list conditions, b.				-				
	Examine	Coupe. Enter Underlying Cause C.								
ted J ansit	Exa	events resulting in death) Last Due to (or as a consequence of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuoreral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	■ UNPENDED □ AMENDED 23a, pt.II,27,per	me,g928 6-4-	12 sm						
O. Box 68760, that the death certificate be ended by the attending physician detached for use as the burial	¥	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	. —	500	23d. Date of deliver					
Box 687 death certificathe attending pool for use as the	cian	past 12 months? 1 Live birth 2 Fetal dr past 12 months? 4 Pregnant at time of death 5 Other	eath 3Ectopic pregna (Specify)	ancy	Month I	Day Year				
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Division of Vital Records, P.O. falo Attending Physiciae: The law requires that the radic death. 12 D. ector: After this certificate has been signed by led it by the funeral director, page 2 should be detach		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		acco use contribute to					
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Vital Records ysiciae: The law requii his certificate has been a	ם			autopsy	ned? death?	completion of cause of				
tal Rection: The certificate		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 only one)	No1	es 2 No				
Vita	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursin	ng Home 5 R	esidence 6 🗸 Othe	r: Scene				
Iing Pl	띪	27. Manner of Death 1 X Natural 5 Paneline 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe ho	ow injury occurred					
Atten r deat r deat by the	cati	Pending Accident Investigation 2 Accident 28e. Place of Injury - At home, farm, street, far	1 Yes 2 No	28f Location (St	reet and Number or Ru	ıral Route Number, City				
Division of popular of Attending Phones after death.	Certification:	3 Suicide 6 Could not be determined (Specify)	atory, omeo panamy, etc.	or Town, Sta		and realistic states of the st				
Division To the Hospital of Attend within 24 hours after deart To the Fuorral Differior completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a								
To the Hos within 24 h To the Fuc completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurred a		nd place, and due to the 29d. Date signed (Mo					
	2	29b. Signature and title of certifier	O.C.M.E.		April 18, 2012	nin, Day, rear)				
- X	ŀ	30. Name and address of person who completed cause of death (Item 23a)								
Oxperen		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimo	re Street, Baltimore, M	D 21223						
Sta Regist	ate		,							
DHMH 17 Rev 1/20		APR 2: (2012 Consistence of the contract of th								
- min i i i i i i i i i i i i i i i i i i		ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #State BeMary and 925 epartment Odf 4 dath and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1857 PM Cyril Mink Poril Medical 2012 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death pital of Baltimore BAHIMORE ina NOS 8. Date of Birth (Month, Day, Year) May 14, 1950 **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Pennsylvania **Director** 204-42-9431 1 ☑ M 2 □ F 61 Usual Residence of Decede 28a-f shov 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Anne Arundel 1 Yes 2 No Glen :Burnie 0 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1111 Castle Harbor Way 21060 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o, þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sysco Food Distribution N/A<u> Heavy Fouirment Mechanic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Mink Catherine Stupy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trait <u> Stacey Mink (Daughter)</u> 749 Powhatan Beach Road Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 04/22/2012 Glen Burnie, Maryland Signature of Fuperal Service Licensee any ir MOO-732 McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Part *Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Reument Aspiration Pneumonia disease or condition Medical resulting in death) Examiner Demontia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence un Examir Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? ☐ Yes 2 No Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident 24 hours after death. Funeral Director: At 1 Yes 2 No Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Gertifying Nurse Practitioner: To the best of My Installedge, death secured at the time 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D72536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N EntanSt Suite 308 Rallimore M.D.

Registrar DHMH 17 Rev 06-201 BHUTANI

2. Registrar's Signature

SUMIT 31. Date filed (Month, Day, Year)

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4.32A. M A Month Lorraine Irene Martin 2 2 20 Year Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE ANNE ARUNDE SALTIMORE IN ACHTUCTION MEDICAL CO WEN Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min 215-28-3931 **Director** 1 M 2 X F Maryland ebruary27, 1932 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director MD Anne Arundel Pasadena 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 1612 Colony Road 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Was Decedon Armed Forces? ¹ ☐ Yes 2 🛣 No er than "natural", or iter the Medical Examiner Black White etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working th and Mental Hygiene.
27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ William Turner Myrtle Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1520 S. Hanover Street Baltimore, MD 21230 Bonnie Zellers daughter Health a M.ARGINI, Department of Healtl Important: If item 2: any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State cemetery crematory or other place) May 1, 2012 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home, P.A. 1270 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE CHRONIC GBETRUGINE RUMONARY CIN ZE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) Pregnant at time of death signed by the a d be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown been signature should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate has funeral director, page 2 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA etely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 45149 terne and address of person who complete ause of death (Item 23a) (Type, Print) leu Burnie MO 20161 ABH 31. Date filed (Month, Day, Year) Regis

DHMH 17 Rev 06-2011

State

Registrar

7 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:05 AM Medical **Examiner** Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 1 Ϊ M 2 🗆 F **Director** 213-28-0497 80 03/11/1932 Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore City 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 1119 Evans Way 21205 United States items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates. 1950's the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Driver Warehouse traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 William . Mount Thelma (Unknown) .f. Page 1 and 2 shou, or of Health and Meron of Health and Meron of Health and Meron of the mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Crystal Orzechowski Daughter permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 8706 Eddington Rd., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ▼ Donation 5 □ Other (Specify) Uniformed Sers. Univ. 04/25/2012 Bethesda, MD Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events he to (or as a consequence of) the burial-tran ue to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Directors. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 No g Unknown g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by WOOT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Decrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title 29d. Date signed (Month, Day, Year) 16 of death (Item 23a), 821

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 50 P M Physician/ APCIL Victoria Lynn Marsellis 2012 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b, City, Town, or Location of Death Franklin Square Hospital Itimore oseda Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs. Year Min 513-70-9007 **Director** 1 □ M 2 🛛 F 51 01/22/1961 Colorado Usual Residence of Deceder show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Baltimore Essex 1 Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 1315 Old Eastern Avenue 21221 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced Marsellis, Victoria 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Entertainer Entertainment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unk. unk. and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amythest Musgrove (Daughter) 6117 Owings Beach Road, Deale, Maryland 20751 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 4/26/2012 Baltimore, Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland 21221 Part 1. Indee the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meta Ph. sician breast di ase or condition re ulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been signated Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 M No Other: ျင 1 Tes 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗆 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 06133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore MD. 21237 Kirmant Ahmed 9000

State

Registrar

31. Date filed (Month, Day, Year)

APR 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monte Physician 7:07 A M 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 61 Maryland Director 215-58-2622 12/14/1950 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 10a. State 10b. County Maryland Baltimore Middle River 1 Yes 2 No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō ral", or Items 23a oi Examiner must be 3707 Bay Drive 21220 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1X Yes 2 If Yes, Give Year or Dates: 2 🗌 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**XX**0 Specify: ģ Specify: unk. White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) College (1-4 or 5+) other than Elementary/Secondary (0-12) the Superintendant Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Bernard Francis McManus Helen Oney traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan McIntosh-Hutton (Wife) 3707 Bay Drive, Baltimore, Maryland 21220 Health 27 permit. Pages 1 as Department of Hee Important: If Item any Injury or othe once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/27/2012 | Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility 21. Si pature of Funeral Service Licen Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shook, or heart failure. List only one cause an each line. Onset and Death Imm viate Cause (Final **Physician** espiratory dise or condition resulting in death) **)**/Medical Due to (or as a conseque ce of) Examiner Squarens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): physician an as the burial-t Box 68760. Physician/Medical the as attending part for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No the Division of Vital Records, P.O. 9 Unknown signed by tall be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 certificate has performed 2 No 2 🗌 No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 - ER/Outpatient 1 Nanpatient 3 DOA မ hours after death.

Ineral Director: After this of filled in by the funeral di 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a, Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

oma

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

barton

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4 23^{Day} 2012 Francoise Pierrette Mizrahi 1:42 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, Year) Davs Hours Min. **Director** 262-58-6831 1 🗆 M 2 🛣 F 85 6-24-1926 France Usual Residence of Decedent 10b. County Director 10c. City, Town or Location 10d. Inside City Limits with the Maryland r 28a-f sl notified DC Washington D.C. 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be Funeral 6205 29th Street NW. 20015 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ō ò Yes 2 X No 1 Never Married 2 Married If Yes, Give 1 Tes 2 No Specify: 3 Widowed 4 □ Divorced "natural" White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene, Republican National Elementary/Secondary (0-12) College (1-4 or 5+) Committee Event Organizer Be other traumatic event, Maryland th and Mental Hy is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jean Joubert Louise Doyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a... Diane D. Mizrahi 15013 Bitteroot Way, Rockville, Maryland 20853 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date o ò 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4-27-2012 Rock Creek Cemetery Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipen ee Brian Deibler 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Ventricular Tachycardia Medical Due to (or as a consequence of): **Examiner** schemic Cardiomyopathy Sequentially list conditions Physician/Medical Examiner cause (Disease or injury Due to for an a commonwork of: that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 2 No 9 Unknown 9 Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State within 24 hours a

To the Funeral C

completely filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the best of my knowledge, death obsumed at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practification and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practification and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) April 23,2012 D50748

State

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Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Georgetown Road, Betherda.

019

31. Date filed (Month, Day, Vear)

TET W. CHAN, MD

Maryland

SUBURBAN HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 13265

		1- For State Registrar		(Certific	ate of	Death			R	Reg. No.			
Physici	an/	Decedent's Name (First, Midd	le,Last)						2	. Date of Dea	ath			3. Time of Death
Medical Exam	iner	Robert Montei	th, III							Month April 24, 2	Day 2012	Year		0653 hrs
		4a. Facility Name (if not institution	on, give street and n	umber)		4	b. City, Town, or	Location				ounty of	Death	
		48 Royalty Circle					Owings Mill	s			Balt	timore	Cour	nty
Funeral		5. Social Security Number	6. Sex	7. Age (In)	yrs. last birt	thday)	If Under 1 Yea	r If Unde	er 24Hrs.	. 8. Date of Birth (MM/DD/Y)				
Director		213-92-4847	1X M 2 F		38	V	Months Day	s Hours	Min.	10/20)/1973	, 1	Foreign	oto() Managed and
· · · · · ·		Usual Residence of Decedent				Yrs.				10/20	1/ 19/3			ntry) Maryland
fun		10a. State 10b. County		10c.	City, Town	or Locatio	on						1	10d. Inside City Limits
* .		Marriland Dalti			0									1 Yes 2 XNo
Maryland 28a-f show	ţċ	Maryland Baltir	юге		Owing	S Mi	LLS 10f. Zip Code				10g. Citizen	- () A O		
Mar r 28,	Director	48 Royalty Circ	al o				Tot. Zip Code	2111	7	[]	lug. Citizen			•
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.								2111					S.A.	·
th wi	Funeral	11. Marital Status 1 Never Married 2 M	12. Was De		in U.S.		Decedent of His s, specify Cubar)- 14.	Race -		an Indian, Black,
The very married 2 warried 1 Yes 2 X No														
after	by		orced If Yes, Give Yes or Dates:				Yes 2 ^X No				Spe	ecify:	Whi	.te
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Spe					s Usual Occupat st of working life.				16b. Kind	of Busi	ness/Ind	dustry
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within and the creek	Ē	,			וטו	sable						able	ed_	
5-6 iled y Hygi	_	17. Father's Name (First, Middle,	•				1	18. Mother	's Name (F	irst, Middle,	Maiden Sur	name)		
21215-0036 ould be filed within 7 is Mental Hygiene. I marked other than ic event, the Medica	Be	Robert Hoke Mor	•	·				Jeni			lerron			
houle m M M	မ	19a. Informant's Name/Relations					Address (Stree							
E T T T T T T T T T T T T T T T T T T T										Land	21221			
f Hear		20a. Method of Disposition	3 Pemoval fr				ion (Name of cer er place)	metery,		Date	20c. Loca	ation - C	ity or T	own, State
Pages ent of		1 Burial 2 A Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bayview Crematory 04/2						04/2	6/2012	Balt	imor	re.	Maryland	
altin nit. J sartm sorts	202. Nemotor of Disposition (Name of Genetery, Crematory of Crematory) 1 Burial 2 Cremation 3 Removal from State 202. Name and Address of Facility 21. Signature of Fureral Service Licenses 222. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Fastory Avenue Facey, Many											7 2010		
		1407 Old Eastern Avenue, Essex, Marylan											land 21221	
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/Medical		failure. Ist only one cause	D	nia										Between Onset and Death
<i>.</i> ∕Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a		ce of):								\rightarrow	
		Sequentially list conditions,	b.										- 1	
	힐	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequen	ce of);									
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876 ifical	5	23b. Was decedent pregnant in th		outcome or p pirth		☐ Feta	ıl death 3 [Ectopic	pregnanc	v	23d. Da	ate of de	elivery Daj	y Year
x 6	Cia	past 12 months?		ant at time o			er (Specify)			,	100			,
Box 687 re death certific the attending red for use as the	Physiciar	1 Yes 2 No 9 Unk	nown 9 Unkno	own										
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P.C. res that signed be dete	b S	Quetiapine To	xicity							1 Yes	2 🗸 No	3	Probal	bly 4 Unknown
Records, The law requir ficate has been s	ete									24a. Was				psy findings available
CO law las e 2 sh	림		<u>-</u>							autop perfor	rmed?	dea	ath?	mpletion of cause of
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of Vital ng Physician: After this certi	P	1 Yes 2 No		npatient 2		tpatient	·			lome 5				scene
Iing P After funera		27. Manner of Death 1 X Natural 5 Pend	28a. Date (Month	of Injury , Day,Year)	286. 1	Time of Inj	· I _ ·	y at Work		ld. Describe I	now injury o	ccurred		
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Division tal or Attendia ts after death. al Director: A	崩		a not be	e of Injury - A	At home, fa	rm, street,	factory, office bu	uilding, etc	c. 28	f. Location (5 or Town, S		Number	or Rural	Route Number, City
pital ours a filled	Certification:	4 Homicide	mined (Specify)											
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	Medical		miner: On the basis of and manner s		on and/or in	vestigatio			curred at th	e time, date	and place,	and due	to the o	cause(s)
	Ž	29b. Signature and title of certifie	г	. /			29c. License	e number			29d. Date	signed	(Month	n, Day, Year)
		6/11/	11/1	1	7		O.C.N	И.E.			April 24	4, 201	2	
	- }	30. Name and address of person	who completed caus	se of death (I	Item 23a)							•		
0			Assistant Medic			W. Ba	Itimore Stree	et, Baltii	more, M	D 21223				
St	ate	31. Date filed (Month, Day, Year)		gistrar's Sig	nature -	-								
Regist	trar	APR 2 7	2012	wa	A.,	pail	20							
DHMH 17 Rev 1/2	001				ORI	GINAL					^	0045		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 24 ay 2012 5:50 P M Salvatore Joseph Miraglia, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Greater Baltimore Medical Cente Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 214-40-6772 **Director** 1 **X** M 2 □ F 68 June 12, 1943 Baltimore, Maryland Usual Residence of Decede ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director Maryland Harford Forest Hill 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1640 Kreitler Valley Road 21050 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 X Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 12 Resource Teacher Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental ပ be Salvatore Joseph Miraglia, Sr. Beatrice Providence Dagostaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 1640 Kreitler Valley Road Forest Hill, Maryland Robert Tabaka (Partner) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of April 28, 20c. Location - City or Town, State Department of Important: If it any injury or o 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Parkville, Maryland 4 Donation 5 Other (Specify) Parkwood Cemetery 2012 22. Name and Address of Facility
Evans Funeral Chapel & Cremetion Services Parkville
8800 Harford Road Parkville, Maryland 21234 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat value. List only one cause on each line. Starty lococcus tureus Phaumania Immediate Cause (Final Pnysician/ methicillin disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No g 🔲 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performe certificate 1 Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Mann Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death. Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier N. Pavillion Suite 550, DOV State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

13267

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 Physician/ April 20, 11:00 P M Moss Doris Agnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Carriage Hill Bethesda Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min. Director 093-30-5346 1 M 2 X F 1926 October 3. 85 Germany Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No Bethesda Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 23a Funeral 20817 United States 6428 Hollins Drive iral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced "natural" Completed White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Agnes M. Steiger Wilhelm C. Grote other traumatic f Health and Nitem 27 is ma 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4804 Enfield Road, Bethesda, Maryland 20814 Oliver M. Moss / Son 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of o = 5 montgomery Montgomery 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or Crematorium, Inc. April 26, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Robert A. Atumbhrevi Funeral Home/Bethesda-Chevy Chase, Inc. this for 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Failure to Thrive Sequentially list conditions, Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury Advanced Dementia and that initiated events Due to (or as a consequence of) resulting in death) Last the burial physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No for Month Day Year Pregnant at time of death 5 Other (specify) detached a \square Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 X Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 🗌 Yes 2 🗆 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined n 24 hou. the Funeral Director Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funer

completely file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier · Cl April 23, 2012 D57124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 10110 Molecular Drive # 206, Rockville, Maryland 20850 Truong Bao, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 04 Medical 4b. City, Town, or Location of Death Name (if not institution, give street and number) 4a. Facility Examiner Baltimore 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign last birthday 6. Sex Funeral Months 1 M 2 Pennsvlvania Director or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10b. County 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a State Director Baltimore Baltimore 1 Yes 2 XX No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21212 6806 Bellona Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. Yes 2 X No 1 X Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mission Helpers of the College (1-4 or 5+) Elementary/Seconday (0-12) Sacred Heart church ministry 1 and 2 should be filed with the stand the should have the stand t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Pauline Smocer Aloysius Minko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sr.Loretta Cornell, MHSH/guardian Towson, MD 21204 1001 W. Joppa Rd. njury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Deportment of H
Important: If ite
any injury or oth 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery Apr. 27,2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedereld Funeral Home Baltimore, MD 6500 York Rd. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer ock, or heart failure. List only one cause on each line. Amerusc Onset and Death Immediate Cause (Final disease or condition Cardiova scular leruh: Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 27 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

31. Date filed (Month, Day, Year) APR 2 7 Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only on

29b. Signature and title of certifier

Ride

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MD

21157

6 112

of Vital Records, P.O. Box 68760	M くしゃんメ じつじゅん ト. Baltimore, Maryland 21215-0036
g Physician: The law requires that the death certificate be executed	
ter this certificate has been signed by the attending physician and novel director none 2 charled he detached for use as the hurial-transit	Department of Health and Mental Hyglene. O Important if item 27 is marked other than "natural", or items 23a or 28a-f show of the state of the stat

		1 - State Registrar		Cer	tificate of L	Death		Reg. No.				
Physici	ion/	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	3. Time of Death			
Physici Med		EDWINA LOUISE M					4		2012	319 AM		
Exami	iner	4a. Facility Name (if not institution, give str			4b. City, Town, or				ty of Death			
d	20	FRANKLIN S Que 5. Social Security Number 6. Sex	7. Age (In yrs. las	CL (If Under 1 Year	If Under 24 F				lace (State or Foreign		
Funera Directo	_		M 2 X F 88	Yrs.	Months Days		lin. (Month, Da		Count			
and show at	l p	10a. State 10b. County	10c. City,	Town or Loc	cation				1	0d. Inside City Limits		
naryk 8a-f s tified	Director	MD. BALT	0.		NOTTING	HAM				1 🗌 Yes 2 🗶 No		
should be filed within 72 hours after death with the Manyland should be filed within 72 hours after death with the Manyland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at		10e. Street and Number 8343 CYPRESS MILL			10f. Zip Code 212	36		10g. Citizen of	f What Coun	try?		
ems r mu	Funeral		2. Was Decedent Ever in U.S.				(Specify Yes or No					
or it	by F	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		f Yes, specify Cuba		uerto Rican, etc.)		ack, White, e	k, White, etc. WHITE		
irs aff		3 🔀 Widowed 4 🗆 Divorced	If Yes, Give A Year or Dates.		∣ Yes 2 X No	Specify:		Specif	<i>y</i> : W	HITE		
2 hot	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	dent's Usual Occup kind of work done o	ation during most of t	working	16b. Kind of Business/Industry				
than the Me	e G	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	O NOT use retired) CASHIER			GROCERY				
d with	Be C	9TH 17. Father's Name (First, Middle, Last)			CADILLER		Nama (Eirat Middle	fliddle, Maiden Surname)				
ylally Mental f Marked o atic eve	101	HARVEY A. WEBSTER					RA DISHMA	,				
2		19a. Informant's Name/Relationship (Type VIRGIL H. MULLENA	Rural Route Numb	er, City or Town, R,MD .	21014°	ode)						
permit. Page 1 and Department of Heal Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ ★ remation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amazzal fram Ctata Ce	metery, cren	sition (Name of natory or other plac CREMATOR	^(e) 4-	Date -28-2012	20c. Location	n - City or To BURNII			
permit. F Departm Importal any injul		21. Signature of Funeral Service Licensee		22	. Name and Addre	me and Address of Facility SCHIMUNEK FUNERAL HOME, INC						
permit Depar Impor		Kenall	e	10.9	9705 BEI	AIR ROA		NGHAM,				
		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death	. Do not ente	er the mode of dyin	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between		
Phy i ian	/	Immediate Cause (Final disease or condition	Preumo							Onset and Death		
Medica	_	resulting in death) Due to (or as a consequence of):										
Examine		Sequentially list conditions, b. C.										
- ·	ine -	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):								
cutec ind trans	xan	Cause (Disease or injury that initiated events c.	Due to (or as a conseque	22222					\rightarrow			
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cate be executed physician and sthe burial-transit	Medical Examiner	d										
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atten for u	ciar	in the past 12 months?	1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnant Other (specify)	су		23d. Date of delivery Month Day Year				
s that the death certigoned by the attendin	Physician/	9 Unknown	9 Unknown									
that the bed by deta	by P	Part II. Other significant conditions con-	ributing to death but not resu	Ilting in the u	ınderlying cause gi	ven in Part I.	23e. Did	tobacco use cor	ntribute to th	e cause of death?		
uires uires uild be	p p						1 🗆	1 Yes 2 No 3 Probably 4 Unknown				
v requires v requires s been sig	Completed						24a. Was		. Were autor	osy findings available inpletion of cause of		
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an: Tl an: Tl tiffical tor, p	Be C	25. Was case referred to medical			26. P	ace of Death (0	Check only one)	2 1 NO	i 🗆 ies	2 10410		
ysici ysici is cer direc	5 B	examiner? 1 Yes 2 No	spital:	ER/Outpatier	nt 3 🗆 DOA Oth	er: 4 🗌 Nursir	ng Home 5 🗆 Res	idence 6 🗆 Ot	ther (Specify			
ig Ph ter th		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur	y at	28d. Describe	how injury occu	rred			
endir eath. or: Af	fica	1 Natural 5 Pending 2 Accident Investigation	(, , , , , , , , , , , , , , , , , ,			Yes 2 No						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office			(Street and Num wn, State)	ber or Rural	Route Number,		
spital sours leral		29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	edge, death	occurred at the time	e, date and pla	ce, and due to the	cause(s) and ma	nner as state	ed.		
he Hos in 24 h he Fur pletely	Medical	(Check 2 Medical Examine	r: On the basis of examination Practitioner: To the best of m	and/or inves	tigation, in my opini	on, death occur	red at the time, date	and place, and o	due to the cau	use(s) and manner stated.		
To the Vith Common Comm		29b. Signature and title of certifier	1 3	······	29c. Licens			29d. Date sign	ed (Month, I	Day, Year)		
		1 / Kelve C. / San	chy, M.D.			7697		04/24/	112			
lev		30. Name and address of person who con Nelia E. Sanchez-	npleted cause of death (Item			sque	ere DR	Balt	o mo	l 21237		
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 2 7 2012	3. Registrar's Signatu									
			- /- /-	14								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Month Physician/ April 23 James Arthur Major, Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE AGNES Hospital If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth **Funeral** Min (Month, Day, Year) Director 214-38-8454 1 🛛 M 2 🗆 F 70 1942 Virginia Feb. 12, Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Howard 1 Yes 2 No Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21075 United States 6920 Montgomery Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Millwright Union Welding Foreman 10th N/A and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle, Last) ည Lillian Bell Moody John Alfred Major 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6920 Montgomery Road, Elkridge, Maryland 21075 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains Virginia Major / Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Page 1 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr. 27, 2012 Elkridge, Maryland nature of F ral Service Licensee 22. Name and Address of Facility BROSE FUNERAL HOME, INC. 1328 Sulphur Spring RD., Arbutus, Maryland alluid 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Syncope Immediate Cause (Final Physician/ hour disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Colonery Vesculer Discore whenown Therosclera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Division of Vital Records, P.O. Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 Director: After this certificate has death? 1 ☐ Yes 2 ☐ No fureral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 1 Inpatient 2 FER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide within 24 hours are death

To the Funeral Director: A
completely filled in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30593 2012 this (23. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTLAGNE, MANTEND Agnes En 31. Date filed State 7 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#30pe DVR G926 4/27/2012 WS For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:42 PM Aprilay 24, 2012 Robert Lee Naumann Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Harford Bel Air If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Days Hours Min Month, Day Year) 1938 Maryland 219-26-2027 Director 28a-f show 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 United States 202 Burkwood Ct. Unit M Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
11 Yes, Give Examiner 0 1 Never Married 2 Married þ 1 Yes 2 No Specify White "natural", 3 Widowed 4 Divorced Completed Year or Dates. Kore 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 'giene. **than** * The City of Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Data Processing Manager and Mental Hygier is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Louise Frances Wright William Naumann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Joanna Naumann /Wife 202 Burkwood Ct. Unit M Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr 27 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Name and Address of Facility

Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as the NaumanniRobert 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director; After the Funeral Director, After the Puneral Director, injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) apperchesapeake Onive Bel Air MD 21015 441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barruet fenmin 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 Day 26 2012 Winnie Duvall Nusz 3:40 AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Months Days 1 🗆 M 2 🖰 F ^{(M}08/08/1926 Country Maryland 220-18-7778 85 Director Yrs 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a 1 🗆 🔀 s 2 🗆 No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Warren Road 21030 **USA** items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed White er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 3:40 life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home is marked other aumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 2012 George S. Duvall Iva Rapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 26, William P. Nusz / Son 28 Somers Court, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 N Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/4/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Dou Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of) **Examiner** BLADDER CANCER Sequentially list conditions, cause. Enter Underlying Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 **X** No Pregnant at time of death 5 Other (specify) Month Day Year detached 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 🗌 Probably 4 🗌 Unknown 1 Tyes 2X No director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I autopsy performed? 2 🗆 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 👿 Other (Specify) မ 1 Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury X Natural 5 Pending 2 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

WINNIE NUSZ Division of Vital the Hospital

State

thin 24 hours a

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

2300 DULANEY VALLEY RD. TRACIE L. MORGAN. CRNP 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

29c. License number

DOB 01/13/1943 DOD 03/24/2012 at 1926 Odensos, George E.

			Type or Prin							-		_	ible.			
	•	State Amend Item 2	25 per me, g	926,047	Cei	72012 tificate	dhb of D	eath	and iv	ientai Hy	Reg. N	e 10. 2 (112	13273		
Physicia Medic		1. Decedent's Name (First, Middle, Las George E. Oden								2. Date of Death March 24 ay 2012 3. Time of Death 7:26 P M						
Examin		4a. Facility Name (if not Institution, give Atlantic General	street and number)				Town, or	Location o	of Death							
Funeral Director			ex 7. Age	(In yrs. last birth	rday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D		9. Birthplace (State or Foreign Country) Mary Land				
aryland a-f show ified at	Director	Usual Residence of Decedent 10a. State Maryland Worcest		10c. City, Town			1						1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No		
with the M 23a or 28 ist be not		10e. Street and Number 2803 Whisper Tra	ace Drive			10f. Zip Code 10g. Citize							en of What Country?			
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	1 X Never Married 2 Married 1 Yes 2 X No					. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 🛣 No Specify:						14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exam	Completed	15. Decedent's E (Specify only highest grant properties) Secondary (0-12)		-)	(Give I	dent's Usua kind of worl O NOT use Offi	k done di retired)		t of worki	ng	16b.	dustry				
Maryland 2 should be filed v th and Mental Hyg 27 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last) George H. Odensos 19a. Informant's Name/Relationship (Type, Print) 18. Mother's Name (First, Middle, Maiden Sun Lillian M. Creager) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow														
e, Mary and 2 should Health and N tem 27 is ma		19a. Informant's Name/Relationship (7) Marge Childs / S		19b.	_{МаіІіг} 308	S. M	(Street a	nd Numbe	r or Rura	Route Numb	er, City o 7 art :	or Town, S S tow n	tate, Zip (, Pa	. 17363		
		20a. Method of Disposition 1		20b. Place of cemeter,	v, cren	natory or ot	her place	p. 3	_	ate /2012	1	Location - WSON ,	•	own, State yland		
Baltimol permit. Page 1 Department of Important: If i any injury or once.		21. Signature of the state of t		,	10	2. Name and 050 Ye	d Address	s of Facilit Road	Ruc Tov	k Tows vson, M	on l lary	Funer Land	al H 212	ome, Inc. 04		
Ph_si_ian/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	plications that caused the cause on each line.	the death. Do no	ot ente	er the mode	of dying	y, such as	cardiac o	r respiratory a	ırrest,			Approximate Interval Between Onset and Death		
Examiner	er	Securationly at an office if any, leading to immediate	Due to (or as a	consequence of	180	ب		(\	s Il	1	KAMINER				
executed ian and urial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence o				CERTIFIC	ATIONAP	PROVED BY ME	Div.			214		
3760 ficate be g physici as the bu	Medica		d													
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown 1 Live Birth 2 Fetal death 5 Other (specify) 1 Fetal death 1 Fe											te of delivery onth Day Year			
ords, P.O. Bo	ρ	Part II. Other significant conditions o	ontributing to death bu	t not resulting in	the u	inderlying c	ause give	en in Part I	l.		Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown					
/ital Records, sician: The law requires certificate has been sig lirector, page 2 should b	Completed									_ perf	s an opsy formed?	F	Were auto prior to co death? I \(\sum \) Yes	psy findings available mpletion of cause of 2 No		
of Vital Physician: this certifiideral directory	To Be	25. Was case referred to medical examiner? 1 A Yes 2 A To	Hospital:	nt 2 🗆 ER/Out	patier	nt 3 🗆 DC	Othe	r: 4 🗌 Nu		only one) me 5 ☐ Res	sidence	6 Othe	er (Specify	·)		
Division of tall or Attending Phas after death. al Director: After the din by the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		Year) 28b. Ti	me of jury	M 28	3c. Injury work?			28d. Describe	how inju	ary occurre	ed			
Divisi		3 ☐ Suicide 6 ☐ Could not be determined	building, etc.	(Specify)					,	City or To	wn, Stat	te)		Route Number,		
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check 2 Medical Examonly one) 3 Certifying Nore	sician: To the best of miner: Or the basis of exa se Practitioner: To the	amination and/or	invest	tigation, in n	ny opinion irred at th	n, death oc ne time, dat	ccurred at	the time, date	and plac	ce, and due	e to the car	use(s) and manner stated.		
with with con		29b. Signature and title of certifier	er m			29c.	D (number 045	8	5	29d. D	24	Month,	Day, Year)		
\/		Acerela 9:	ompleted cause of dead	Hay		Dru	ir	Be	eles	, put	2	21	1811			
Stat Registra		31. Date filed (Month, Day, Year) APR 2 7 20	12 Registrar	's Signature	pa	Mal				_						

#

12-02918 Jerome Oakley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar Certificate C		70	g. No. 201	2 327					
Physici edical Exami				2. Date of Deatl	h	3. Time of Death 0820 hrs					
	mei	Jerome Oakley 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	Month April 14, 20	012 4c. County of Death						
		Patauxent Institute	Jessup		Howard						
Funeral Director		5. Social Security Number Unk 1 X M 2 F 69 Vi Usual Residence of Decedent	If Under 1 Year If Under 24Hr Months Days Hours Min		h(MM/DD/YYYY) 9. Birt Foreig Cou						
iow any		10a. State 10b. County 10c. City, Town or Local MD Howard Jessup	ation			10d. Inside City Limits 1 Yes 2 X No					
ie Maryland or 28a-f show any fied at once.	Director	10e. Street and Number 7555 Waterloo Road	10f. Zip Code 20794	10	og. Citizen of What Coun USA						
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral D		/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto			can Indian, Black,					
after de	by Fu	3 Widowed 4 Microsoft If Yes, Give Year 1	Yes 2 No specify:		Specify:	ack					
hours "natur	ted k	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of most of working life. DO NOT use re	work done tired)	16b. Kind of Business/Ir	ndustry					
21215-0036 suld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Completed	12yrs War	d of State		Ward of	State					
215- be filed ntal Hyg rked ot	Be	UNK	UNK	e (First, Middle, M	laiden Surname)						
MD 21 d 2 should lith and Me n 27 is ma	To	Pala Informant's Name/Relationship (Type, Print) Elaine Rasheed Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Statement 8706 Inwood RD Baltimore MD 21244									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from State crematory or call 4 Donation 5 Other Specify:	ther place) Crem 04	Date /24/12	20c. Location - City or T	e MD					
Balti permit. Departu Import		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility SinhomasAllen PA 70	_							
Physician /Medical	F	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.				Approximate Interval Between Onset and					
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Card Due to (or as a consequence of):	liovascular Disease			Death					
	-6	Sequentially list conditions, if any, leading to immediate b									
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
recuted and ransit											
60, ate be ex ohysician ne burial	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			Tool Detected						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Physician/N										
O. Bat the date date by the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e, Did tob	acco use contribute to the	ne cause of death?					
ls, P.C quires that en signed ald be deta	ted by	Chronic obstructive pulmonary disease, diabetes mellitus, e	ndstage renal disease	1 Yes	2 No 3 Proba	bly 4 V Unknown					
of Vital Records, P.O. of Physician: The law requires that the this certificate has been signed by there this certificate has been signed by meral director, page 2 should be detailed	Completed			autops perform 1 Yes 2	y prior to co ned? death?	mpletion of cause of					
ital sician: is certification	B	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check		tesidence 6 🗸 Other:	Scono					
on of Vital Inding Physician: ath. r: After this certifier the funeral director,	tion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of			ow injury occurred						
Division spital or Attendia tours after death. neral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree (Specify)	et, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rura ate)	al Route Number, City					
To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.									
E > E 3	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	1	29d. Date signed (Mont	h, Day, Year)					
	}	30. Name and address of person who completed cause of death (Item 23a)	U.U.IVI.E.		April 18, 2012						
V		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. I 31. Date filed (Month, Day, Year) 32 Registrar's Signature	3altimore Street, Baltimore,	MD 21223							
St Regist	ate :rar		الما								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1: 00 AM C Olver hons 72 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cal Ver White 45 by Sad S If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Months Days Hours Min Director 575-66-7461 70 11/28/1941 Korea Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Tre Modical Examinating the multiled at Y☐Yes 2☐No Director MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1247 White Sands Drive 20657 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 Yes 1 No
If Yes, Give
Year or Dates: 1 Never Married X Married altimore, Maryland 21215-0036 1 □Yes 🏋 □ No Specify: 2 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Trader 12 Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Kook Chang Dong Choi Chang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traunonce. Thomas J. Owen / Husband 1247 White Sands Drive, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial X ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/26/2012 Beltsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Borota Marshall Maryland Cremation Services, PO Box 1413 Baltimore. MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final heimer , Physician 4 EZRS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transi Due to (or as a consequence of): Box 687605 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4☐ Pregnant Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been si page 2 should b 1 ☐ Yes 2 Z No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy The certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 PAesidence 6 Other (Specify) 1∐ Yes 2 1 No Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie

DHMH 17 Rev 1/2001

State Registrar Three Notch RD, Suite 2054, Colifornia, MD 20619

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John S. Tidbell.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician/ 09: 10 PM Peay Aboll Rosemary 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Siva Hospital of Baltmore Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 220-64-7820 1 🗆 M 2 🗶 F Director 59 52 MD 06 14 Usual Residence of Decedent Kosemasy Peay ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 ☐ No Baltimore MD NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 6628 Vincent Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ 2 should be filed within 72 hours after h and Mental Hygiene.
7 is marked other than "natural", or traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Dept. Elementary/Secondary (0-12) College (1-4 or 5+) Data Processer Environment 2th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Thomas Lightner other traumatic Sadie Taylor Department of Health an Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1382, Cockeyville, Md 21030 Ingrid Rudolph-Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Woodlawn, Md King Memorial Park5/1/2012 21. Signature of F 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EXTENSIVE INTRAVENTRICULAR MEMORRHAGE Physician/ day disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): GANGUA HEMORRHAGE EFT BASAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION attending physician and Due to (or as a consequence of): MRONIC KIDNEY DISEASE Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an funeral director, page 2 BREAST CANCER Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4- Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 \sum Yes 2 \sum No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

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Known

D

Registrar

Medical

29a Certifier

(Check only one 29b. Signature and title of certifie

Verma

RES-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Aboil 22, 2012

Mospital of Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Anu Verma , MBBS Sinou

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9926 4-27-11 vt.
State of Maryland / Department of Health and Mental Hygiene 13277 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Everett Marshall Pywe11 7:07 P M April 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 3158 Gracefield Rd. #615 Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. _{Yea}1929 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min June 11 Country)
Washington DC 1**火** M 2 □ F **Director** 82 577-32-3933 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f sho must be notified at the Maryland Director MD Prince George's 1 Yes 2 X No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3158 Gracefield Rd. #615 20904 United States items death 1 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo Specify: Specify: "natural" Completed 3

Widowed 4 □ Divorced White Year or Dates. 1951-53 the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than 's event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Vice-principle / Teacher Education / Music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 of Health and Menta fitem 27 is marked other traumatic e Ernest Everett Pywe11 Ida Lucile Rockwell 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Bain Lowry / Sister 6208 Bayhill Lane, Sebring, FL 33876 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 04/26/2012 Beltsville, MD 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PAROXYSMAL ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events DIABETES MELLITUS and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Hospital or Attending Physician; The law requires that the death of 24 hours after death.
 Funeral Director. After this cartificate has been signed by the atterested filled in by the funeral director, page 2 should be detached for rested filled in by the funeral director, page 2 should be detached for rested filled in by the funeral director. Live Birth 2 Live Great Son Pregnant at time of death Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 😾 No ್ತ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5XXResidence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) No sen 14/ D59524 APRIL 23, 2012 rumang, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar PUTHUMANA.

31. Date filed (Month, Day, Year)

M.D

3110 GRACEFIELD RD., SILVER SPRING, MD

20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 700 AM 25 2012 Gene Marie Pinter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rosedal Baltimor FRANKLIN Square HospiTal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🕱 F 85 171-24-2808 06/30/1926 Pennsylvania **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Mydical Exantive in ust be notified at once. 1 ☐ Yes 2X No Maryland Baltimore Essex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1807 Middleborough Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Xo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XQXNo ģ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cristina Peluso Lucca Rapanotti မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christine Pierorazio (Daughter) 610 Highvilla Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard: 04/27/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Lieuwa 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imp diate Cause (Final **Physician** 400 Sepsis esulting in death) /Medical Due to (or as a consequence of): Examiner heart estiv ~ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit cirrhosis Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Interstital diseas IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death ☐Yes 2 ☑No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊿No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

State Registrar 29b. Signature and title of certifier

Panna

31. Date filed (Month; Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorototas

29d. Date signed (Month, Day, Year) April 25, 2012

9000 FRANKLIN Square DR Balto Md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH C927 5/08/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 25^{Day} 2012^{ear} Physician/ 7:05 a M Aniello Prisco Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center **565** Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days New York Months Hours 89 Director 1 XM 2 F Feb 25, 1923 Usual Residence of Dece 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director notified 28a-f s MD Baltimore Lutherville 1 🗆 Yes 2 Ϊ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b gonee. 7 Oakridge Court 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Claims Examiner Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Prisco Miguelena Mirabella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Oakridge Ct., Lutherville, MD 21093 Rosemarie T. Prisco-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Arlington National 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schemic Cardionyopell disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Petal uea Pregnant at time of death in the past 12 months? Month Day Year signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 this certificate 2 🗌 No 1 Tyes funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 - Nursing Home 5 - Residence (Specify) No 37 We 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Charle, T2 NoconsT CHARLES 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAURITIA **PATCHA** APRIL 2012 7:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2901 CABIN CREEK DRIVE BURTONSVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year MARCH 13 Director CAMEROON 218-33-8570 1 🗆 M 2 🕱 F 72 1940 Usual Residence of Decedent or 28a-f shov 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Yes 2 No MD MONTGOMERY BURTONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2901 CABIN CREEK DRIVE 20866 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc ģ ☐ Never Married 2 ☐ Married Maryland 21215-0036 3 Widowed 4 Divorced 1 ☐ Yes 2X No Specify: AFRICAN Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 721 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL WORKER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PHILLIP SATIA THECLA ASONGATE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 is WILLIAM ADAMU/SON INLAW 2901 CABIN CREEK DRIVE BURTONSVILLE, MARYLAND 20866 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cemetery
cared Heart Parish 1 X Burial 2 Cremation 3 Removal from State any injury or 5/24/2012 FIANGO KUMBA CAMEROON 4 Donation 5 Other (Specify) Scared Signature of Funeral Service License J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Na 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events burial-tran Due to (o a a consequence of resulting in death) Last physician s the burial Physician/Medical that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Hospital ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending injury 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifie 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) APRIL 25, 2012

H ✓ State

FREDERICK MIN MD 2101 MEDICAL PARK DRIVE #200 SILVER SPRING, MARYLAND 20902
31. Date filed (In France Park Year) 200 Page Segistrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

pares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April DOLORES 1201 PM JANE PHILLIPS 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Burnie Baltimore Washington Medical Cer Glen Anne Arunde Her . Age (In vrs. last birthday If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 183-24-6707 **Director** 1 🗆 M 2 🗶 F 80 Usual Residence of Decedent 12/24/1931 Pennsylvania 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 606 Pearl Point Court 21108 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) Homemaker Own Home Be Solores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Hill Mary Elizabeth Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is any injury or act. Mrs. Diane Seabolt Daughter 606 Pearl Point Court Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) April 25 2012 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue S.W. Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiogenic disease or condition 2 days Medical resulting in death) Due to (or as a consequence of) Examiner Myocardial Infartion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as attending p 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 1 months? Pregnant at time of death Month the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Kidney Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Cardio myopat Were autopsy findings available prior to completion of cause of 24a. Was an has , page 2 autopsy perform death? this certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) pital: 1 N Inpatient 2 DER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year) 28b. Time of injury
injury 28c. Other: 1 🗌 Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of Manner of Deal Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature, and title of certifier 29c. License number Name and address of person who completed sause of death (Item 23a) (Type, Print)

+ ARVIN DER SINGH ARORA B GLEWBURNIE, MD 21061 HOSPITAL, WMC

DHMH 17 Rev 06-2011

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registra

P.O.

CENTER

DANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUSINESS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:10PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Country) **Funeral** Year) Months Days Hours Min. NORTH CAROLINA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country POLLIGE PARK items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Defes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 Specify: BLACK 1 ☐ Yes 2 No Completed by Specify: 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be is marked Health Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any Injury or o oonce. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08550 23a. Pa ... Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory area Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** stage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day P.O. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by ₽Z No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2 **X**No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Division 5 Pending investigation 1 □ Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

DS 753

Mullersville

29d. Date signed (Month, Day, Year) 23.

and manner stated.

8601 Veterans

W.J

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	Funeral Director		5. Social Security Number 6. Sex		rs. last birtho		ar If Under 24 H		th y, Year)	9. Bir Co	thplace (State or Foreign		
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	with the Ma 23a or 28 ust be noti		10e. Street and Number	Coad		10f. Zip Coo	กา เ		_	Citizen of What Co				
980	led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 12 Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	ı U.S.	13. Was Decedent of If Yes, specify C	Specify Yes or No- erto Rican, etc.)	pecify Yes or No- o Rican, etc.) 14. Race Blac Specify:			e - American Indian, k, White, etc.			
21215-0036	ed within 72 hour Hygiene. other than "natu ent, the Medical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(0	Decedent's Usual Oc Give kind of work do fe. DO NOT use retir Ridin	rorking	Kind of Business/Industry Horse Training						
	e d ta	To Be	17. Father's Name (First, Middle, Last)	erbert Palmer			lame (First, Middle, Katheri i		Surname) nabel Cours	rsey				
_	d 2 sh alth ar 1 27 is er trau		19a. Informant's Name/Relationship (Type, Brian H. Pickett Spouse	Print)	19b. I	Mailing Address (Stre 21 Beetz Rd.	et and Number or I Mount Airy,	Rural Route Numbe	er, City o	or Town, State, Zi				
Baltimore,	permit. Page 1 and Department of Hee Important: If item any injury or othe once,		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		b. Place of E cemetery, St. Paul'	Disposition (Name of crematory or other ps Lutheran Cer	netery Ap	Date r 26, 2012	20c. l	Location - City or Fulto	Town, S			
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensea	Roltur	11102	22. Name and Ad Slack 3871 O	uneral Home, Id Columbia F	P.A. ike Ellicott C	ity, M	D 21043				
	Physician/ Medical Examiner pnuial-transit	cal Examiner	23a. Part 1. Siter the difference of complications shock, or heart fail re. List only one of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of	breast					Inter	oximate val Between st and Death		
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed Attending death. A hours after death. Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the burial-transit		JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	i. If yes, outcome of pre 1 Live Birth 2 4 4 Pregnant at time 9 Unknown	Fetal death	3 ☐ Ectopic pregr 5 ☐ Other (specify				23d. Date of de Month	livery Day	Year		
rds, P.O.	requires that the been signed by should be detact	2	Part II. Other significant conditions contr	buting to death but not	o death but not resulting in the underlying cause given in Part I.			_ 1 🗆	Yes 2	use contribute to	robably	4 Unknown		
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Vital	ysician; The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	spital:	ER/Outr		. Place of Death (Cl Other: 4 \(\sum \) Nursing	heck only one) Home 5 Resi	dence	6 ☐ Other (Spec	cify)			
n of	ding Phys th. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year	28b. Tir	me of 28c. In	njury at ork? ☐ Yes 2 ☐ No	28d. Describe I			,			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farn			28f. Location (City or Tov		nd Number or Ru e)	ral Route	e Number,		
	e Hospit n 24 hour e Funera eletely fill	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examiner only one) 3 Certifying Nurse F	: On the basis of examin	ation and/or i	investigation, in my o _l	pinion, death occurre	ed at the time, date a	and plac	e, and due to the	cause(s)	and manner stated.		
	To the within 2 To the Comple	-	29b. Signature and title of certifier	1		29c Lice	nse number		204 D	ate signed (Mont	h Day V	ear) 2012		
)			30. Name and address of person who com	pleted cause of death (Item 23a) (Ty	rpe, Print)	st, CR	B1-153	B	altimo	۲,	mo 2123		
	Sta Registr		31. Date filed (Month, Day, Year) APR 9.7 2012	32. Registrar's Si	gnature	Kel								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 24 Day 2012 Pear 10:05 PM James Robert Parker III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number Funeral (Month, Day, Months Days V<u>irginia</u> 1 🛛 M 2 🗆 F Hours Min 1950 Director Mar. 219-54-5297 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 XNo Harford Bel Air Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21015 1817 Selvin Drive #303 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Was Decedent Ever in U.S. Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No |arphi arphi|/arphi | igcup igcup arphi arphi|Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: "natural", White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mechanical and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Contract Negotiator Contracting Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Elaine Jeanne Charland James Robert Parker Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1004 Telford Court, Abingdon, Maryland 21009 Jennifer Pa<u>trick /</u> Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ fregmation 3 ☐ Ren cemetery, crematory or other place, State 4/28/2012 4 Donation 5 Other (Specify) Air Memorial Gdn; Bel Air, Maryland Signature of Fun 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Due to (or as a consequence of) Exami burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Robert attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for a Day Month Pregnant at time of death Parker, James Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determin City or Town, State) within 24 hours a To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel AIV MD 500 upperchosapeake Dr Alade unola 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

		State Registrar			Cer	tificate of E	Death			Reg. No	٥.			
Physicia Medi		1. Decedent's Name (First, Middle, L Katherine R	^{ast)} Rinke	r		-			2. Date of De Month April	24, Day 2012 Year			3. Time of Death 7:20 AM	
Exami		4a. Facility Name (if not institution, gi	ve street and number)			4b. City, Town, or	Location	of Death	-	$\overline{}$	c. County of	Death		
~ L	н	National Luther				Rockvil				Montgomery				
Funeral Director		Social Security Number 224-68-0387 Usual Residence of Decedent	Sex 7. Age 1 M 2 T	e (In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under Hours	8. Date of Bir May 7,	rth 9. Birthplace (State or Foreign County) Virginia					
and Show	5	10a. State 10b. County		10c. City, Town	or Loc	ation						10	d. Inside City Limits	
Maryla Ba-fa tified	lec	MD Montgo	omery	Rock	vil:	le							1 ☐ Yes 2 🛣 No	
with the I	Funeral Director	10e. Street and Number 9701 Viers Drive	2		_	10f. Zip Code 20850				10g. C	itizen of Wha	at Count	ry?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nivury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	n, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Black, Specify:	America White, e	tc.	
15-C	plet	15. Decedent's (Specify only highest)			(Give k	ent's Usual Occupa		t of worki	ng	16b. k	16b. Kind of Business Industry			
ithin 7 ene.	3 Widowed 4 Divorced Pear or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker									()wn Ho	Home		
iled w Hygi other	Be	17. Father's Name (First, Middle, Last)				18. Moth	er's Name	(First, Middle,		Maiden Surname)			
/land de formal	P William Jennings Goodwin								hleen	Pace	2			
, Maryland d 2 should be filed talth and Mental Hy n 27 is marked oth		19a. Informant's Name/Relationship David Rinker - S								Route Number, City or Town, Si			ode)	
Baltimore, bermit. Page 1 and Department of Hea mportant: If item any injury or other		20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3	Removal from State	20b. Place of cemeter)	Dispos	ition (Name of atory or other place	e)		ate	20c. L	ocation - Ci	ty or Tov	vn, State	
ti. Pag rtmen rtant:		4 Donation 5 Other (Spe	cify)	Nationa	_	Mem. Park			/2012				h, VA	
Bal permit Depar Impor any in		21. Signature of Funeral Service Life	DO NO	\circ	22.	Name and Addres							Service VA 22310	
		23a. Part 1. Enter the disease, or co shock, or heart failure. List only	nplications that caused	the death. Do no	ot enter	the mode of dying			_				Approximate	
—Ph _y sician		Immediate Cause (Final disease or condition	Λ	in ins		DEME		100					Interval Between Onset and Death	
Medical Examiner		resulting in death)		consequence of	f):	17 6 1.6	10 11	11				1		
Д истино	er	Sequentially list conditions, if any, leading to immediate	b. Due to for as a	a consequence of	n.							+		
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760 Cc cate be executed physician and sthe burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequence of	f):							_		
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58760 ertificate b ding physice as the b	₩e.	IF FEMALE:								- 1				
Hecords, P.O. Box 68760 The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death		Ectopic pregnancy Other (specify)	у				23d. Date of Month		y Day Year	
P.O. that the ned by detac	by Pr	Part II. Other significant conditions	contributing to death be	ut not resulting in	the ur	derlying cause giv	en in Part	I.	23e. Did to	obacco i	use contribu	te to the	cause of death?	
dS, tuires en sign	ed b								1 🗆	Yes 2	No 3	☐ Proba	ably 4 □ Unknown	
aw rec as bee 2 sho	Completed								24a. Was		24b. Wer	e autops	sy findings available	
/ital Reco sician: The law i certificate has t lirector, page 2 s	Com								perfo	rmed?	dea			
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Phys Phys	<u>ن</u> 1	1 Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 ER/Out	_	3 DOA Othe	4 LX N		ne 5 Resid		-	Specify)		
on C nding ath. :: After e fune	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Day,		jury	work'			8d. Describe h	iow injur	y occurred			
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate:	3 Sulcide 6 Could not 4 Homicide determined	be 280 Place of Inju		n, stre	et, factory, office		2	28f. Location (S City or Tow			r Rural F	Route Number,	
Ospital I hours Uneral	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of r	my knowledge, d	eath o	ocured at the time,	date and	place, and	due to the ca	use(s) ar	nd manner a	s stated		
thin 24 the F the F mplet	Me	only one) 3 Certifying Nu	miner: On the basis of ex rise Practioner: To the b	pest of my knowle	dge, de	eath occurred at the	time, date	and place	, and due to th	e cause(s	s) and manne	er as stat	ed.	
5 ≥ 5 0 0		29b. Signature and title of certifier	wz			29c. License		CC		29d. Da	ite signed (M		ay, Year)	
		30. Name and address of person who		eath (Item 23a) (Ti	/De Pr		0511	22		1714		7		
3		VATTI AWTHON		VEIN	_	かいし	Ro	CICU	ILLE	n	0 201	50		
Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2	32 Registra	r's Signature	ha	Mad								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patneray. 2:08 PM Robin 22 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical Center Baltimore University Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 117-70-8233 Months Days Hours **Director** 1 M 2 X F 41 Jan. 30, 1971 Antigua Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director Bethesda 1 🗌 Yes 2 🏝 No Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5401 Westbard Avenue #213 20816 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Social Worker Non-Profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Beatrice Remy Almour Robin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13010 Hathaway Drive, Silver Spring, Maryland 20906 Abiola Folarin/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of April 28, 2012 20c. Location - City or Town, State Montgomery or other place) Crematorium, Inc. 1

Burial 2

Cremation 3

Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Sovice Licensee M00198 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Subarachnoid Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Arterio-Venou! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗆 No မ I 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural Natural 5 Pending 2 No Accident Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Mansoor

31. Date filed (Month, Day, Year)

S. Grz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

22

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 935 RUSSEII Apri AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death None Johns Hopkins HOSPITAL Baltimore .Hu Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 224-52-9739 71 Director 1**XX** M 2 □ F 05/03/1940 Virginia Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2XX No Virginia Lancaster Weems 10e. Street and Numbe 10f. Zip Code 5 10a. Citizen of What Country? 23a by Funeral 22576 83 Kingfisher Circle USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ral", or iten Examiner Race - American Indian, Black, White, etc. Armed Forces?

XXYes 2 \[\] No
f Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify "natural", 3 Widowed 4XX Divorced Specify: Black Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Director of Human Developement Federal Government of Health and Mental Hygier fitem 27 is marked other t r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Lou Robert Russell Ernestine Hanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Stephanie Ann Russell DTR 15090 Oaks Road Charlotte Hall, Maryland 20622 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 0 Northern Neck Crematory Department of Important: If any injury or 04/27/2012 Warsaw, Virginia Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Day be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed' death? this certificate Hospital or Attending Physician: ' 24 hours after death. Funeral Director; After this certific 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) 1 Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1XI-Natural 5 Pending work 1 Tyes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, Conties n/ un 2012 April Res- 600

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State

Registrar

Karthikeyan

31. Date filed (Month, Day, Year)

APR 2 7 2012

wolke

Street Baltimore

WD

21207

North

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennusamy

600

32. Registrar's Sign

12-03137 Gary Richard St	eve		pe or Print i tate of Maryla						Legib	le.		
oury monard of		1- For State Registrar	late of Maryl		rtificate of		iu ivientai	riygierie	Reg. N	. 20	112	1328
Physici	an/	Decedent's Name (First, Midd	fle,Last)				-	2. Date of Month	Death Day	/ Year	3	3. Time of Death
Medical Exami	ner	GARY RICHARI 4a. Facility Name (if not institution				b. City, Town, o	r Location of De	April 2	3, 2012	4c. County of	Death	0226 hrs
		4 Winehurst Road	on, give street and m	ambory		Catonsville		Sour		Baltimore		ty
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye		Hrs. 8. Date o	of Birth (MI		9. Birth Foreign	place (State or
Director		216-54-1829	1 <u>√√</u> M 2 F	60	Yrs.	IVIOTILIS DA	ys flours	08/	08/1		Cour	
ku a		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Location	on					1	10d. Inside City Limits
*	ō	MD BAI	LTIMORE		CATONSV	ILLE						1 Yes 2 XXNo
Maryl r 28a-i	Director	10e. Street and Number	•	-		10f. Zip Code			10g. C	itizen of Wha	t Countr	y?
rith the 23a o		4 WINEHURST F		cedent Ever in U	c 13 Was	2 Decedent of H	1228	(Specify Ves o	r No.	USA	America	an Indian, Black,
leath w	Funeral	1 X Never Married 2 N				es, specify Cuba				White,		iii jiididii, black,
ral", o	by F		vorced If Yes, Give Yes	ar		Yes 2∑X N				Specify:		HITE
2 hours		15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Decedent during mo	's Usual Occupa est of working life	ation (Give kind e. DO NOT use	of work done retired)	16b	. Kind of Bus	iness/Ind	lustry
21215-0036 In the before the Maryland did be filed with 72 hours after death with the Maryland Mental Hygiene and matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once,	Completed		1	,	PAI	NTER				PAIN	TINC	1
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle		_				ame (First, Mide	tle, Maide			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	SIDNEY IRVINO 19a. Informant's Name/Relations		תי	19b. Mailing	Address (Stre	SYLVI. et and Number		Number,		BURF , State, 2	
MD d 2 sho lith and n 27 is		ALLAN ROSENFE	ELD/BROTHE			EE STRE						
of Heal		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal fi	(1010	Place of Disposi	er place)		Date	200	c. Location - (City or To	own, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	, , ,		MIKRO KO ISRAEL	CEMETER'	Y	4/26/20		BALTI		
Bal permi Impo injur	ļ	21. Signature of Punetal Sprice	Cuttle			ame and Addres		SOL LEV				
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death								Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	_{a.} Hypertensi			ovascular Di	sease					Death
-		Sequentially list conditions,	b.	a consequence o	т):							
	ie	if any, leading to immediate cause. Enter Underlying Cause		a consequence o	f):							
18 =	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	f):							
Vital Records, P.O. Box 68760, vicini: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	-1	UNPENDED	dAMENDED									
60, ate be e hysicia	an/Medica	IF FEMALE:	23c. If yes,	outcome of preg	nancy				2	3d. Date of d	elivery	
Box 68760 e death certificate b the attending physical for use as the bu	jan/	23b. Was decedent pregnant in t past 12 months?	I I TIVE	oirth nant at time of de	ath -	al death 3	Ectopic pre	gnancy	8	Month	Da	y Year
Box death the atte	hysici	1 Yes 2 No 9 Un	known 9 Unkn		5 Oth	er (Specify)			-			
P.O. es that the gned by re detach	by P	Part II. Other significant condi	tions contributing to	o death but not r	esulting in the ur	nderlying cause	given in Part I.				_	e cause of death?
ds, Fequires									Vas an			psy findings available
Division of Vital Records, and or Attending Physician: The law requirers therefore. After this certificate has been sined in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second	Completed							_ P	utopsy erformed	? de	ath?	npletion of cause of
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n of ding Ph. After the funeral	ë ::	27. Manner of Death 1 V Natural 5 Pen		of Injury n, Day,Year)	28b. Time of In		uryat Work? Yes 2 No	28d. Descr	ibe how in	njury occurre	d	
ivision or Attend after death Director in by the	Certification:	2 Accident Inve	stigation	ce of Injury - At h	ome, farm, stree					and Number	or Rura	I Route Number, City
Div pital o ours aff filled i	Serti	4 Homicide dete	ermined (Specify)					or Tov	vn, State)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executability thours after death. After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial - tr		Torreaction,	hysician: To the bearing.	•	-							
To t To t com	Medical	29b. Signature and title of certifi	and manner s				se number			I. Date signed		
		Cl Gens	\			0.0	.M.E.		Ap	oril 23, 201	12	
2		30. Name and address of person				Him a 21	-4 D 14!	. MD 0400	,	1000		
	ate	Laron Locke MD. A 31. Date filed (Month, Day, Year)	ssistant Medica	al Examiner egistrar's Signatu	73.77		et, Baltimore	е, мр 2122	3			
Regist		APR 2	7 2012 1	me /	1. pa	Ker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 00 M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Howard Columbia Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) 462-38-0719 Director 1 □ M 2 🗓 F April 24, 1921 Kentucky 91 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Howard Jessup 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9950 Guilford Road; Apt#217 20794 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Potter Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Stella Gambill Roscoe Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11878 Simpson Road Clarksville, Maryland 21029 (Son) Ken Steil Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4-27-2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ be detached for in the past 12 months? Month Day Year Pregnant at time of death 2 1110 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 NO 1 🗌 Yes Yes 24 completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Doatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending iniurv after death. 2 No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 April 27 4:48 Robert Shenton Α Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Pasadena Locust Lodge 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours **Director** 213-24-4384 1 X M 2 F Feb. 13,1927 85 Usual Residence of Dece fshow 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits at Director must be notified 28a-1 1 Yes 2 X No Anne Arundel <u>Maryland</u> Glen Burnie 10f. Zip Code 5 10e. Street and Numbe 10g. Citizen of What Country? with 23a Funeral 21061 U.S.A. 601 Blossom Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or item I Examiner n 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: U.S.A. 27 is marked other than "natural", raumatic event, the Medical Exal 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Produce Manager Fort Meade 11 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Shenton Ida Cohiggen Robert Η. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 601 Blossom Lane Glen Burnie, Maryland 21061 Marian L. Shenton (Wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of F Important: If ite any injury or otl once. cemetery, crematory or other place, 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 04/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemeterv Brooklyn Park, Maryland 21. Signature of Fugeral Service Licenses 22. Name and Address of Facilit MOO-732 McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part * Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Cardo Vasculas Interval Between leiotiz Onset and Death Immediate Cause (Final Physican 110 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rs after death. al Director: After this certificate ha lled in by the funeral director, page performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Tyes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No __ Accident Investigation 6 Could not be

within 24 hours To the Funeral

State

filled in

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boris hristopher Da 7

determined

NO

3 Suicide 4 Homicide

only one

29b. Signature and itle of certifie

29a. Certifier (Check

> 3708 Mountain 32. Registrar' Signati

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

242820

Rd

Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Pasadena Midaliaz

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		•	1 - State of Mar State Registrar		partment of F e <i>rtificate of E</i>			eg. No. 201	2 13292
Ī	Physicia		1. Decedent's Name (First, Middle, Last) Henry B. Snyder III				2. Date of Death	Day Year 23 201	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) 7704 Gough Street	<u> </u>		Location of Death		4c. County of Deat	th
	Funeral Director			n yrs. last birthday 67 Yrs.			8. Date of Birth (Month, Day, Dec • 1	9. Bir	imore thplace (State or Foreign untry) MD
	Maryland 28a-f show otified at	Director		0c. City, Town or I	Location timore				10d. Inside City Limits 1 Yes 2 No
	s 23a or 3	Funeral Di	10e. Street and Number 7704 Gough Street		10f. Zip Code	1224	1	0g. Citizen of What Co USA	ountry?
9000	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ ★No If Yes, Give Year or Dates.		3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	iled within 72 how Il Hygiene. other than "nat vent, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 10th College (1-4 or 5+)	(Giv	cedent's Usual Occupa ve kind of work done d DO NOT use retired) Vy Equipr	uring most of working	9	16b. Kind of Business Picorp	Industry
Maryland 2	should be filed w n and Mental Hygi 7 is marked other raumatic event, i	To Be	17. Father's Name (First, Middle, Last) Henry Snyder Jr.	1200	1-1-1-1	18. Mother's Name	(First, Middle, M		
	1 and 2 should be of Health and Men item 27 is marker other traumatic		19a. Informant's Name/Relationship (Type, Print) Terri Snyder /wife	I				City or Town, State, Zij imore MD	,
Baltimore,	permit. Page 1 ar Department of He Important: If iten any Injury or oth		20a. Method of Disposition 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	cemetery, cr	position (Name of rematory or other place Hill Cer	e) !		20c. Location - City or Baltimo	
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Survice Licensee		22. Name and Addres	50		Ave. Bal	lto. MD ssex 21221
J	Pnysician/ Medical			IX CA		g, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
مسي	Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a co						
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co						
200	physiciar the buris	edical	d						
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of £ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc	У		23d. Date of de Month	livery Day Year
ds, P.O.	luires that th en signed by uld be detac	by	Part II. Other significant conditions contributing to death but n	not resulting in the	e underlying cause giv	en in Part I.		acco use contribute to	the cause of death?
Division of Vital Records, P.O.	: The law rec cate has bee	Completed					24a. Was an autops perform	y prior to o	topsy findings available completion of cause of
Vital	ysician: nis certifi director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpati	Othe	r: 4 Nursing Hom		nce 6 🗆 Other (Spec	ify)
ion of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 or	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	ear) 28b. Time injury	work	at 28 ? Yes 2 \(\text{No} \)	3d. Describe hov	w injury occurred	
Divisi	ital or Att urs after d ral Direct	al Cert	4 Homicide determined 28e. Place of Injury - building, etc. (S	Specify)			City or Town,		
	the Hosp hin 24 hou the Fune mpleted fi	Medical	29a. Certifier (Check check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 4 Certifying Nurse Practioner: To the best of my Check only one) 4 Certifying Nurse Practioner: To the best of my Check on the my Check on	nination and/or inv	estigation, in my opinion e, death occurred at the	n, death occurred at ti time, date and place,	he time, date and and due to the o	d place, and due to the cause(s) and manner as	cause(s) and manner stated. stated.
	D wit		29b. Signature and title of certifier MD		29c. License	637-83	29	Am 7, 25,	n, Day, Year) 2012
	5V		30. Name and address of person who completed cause of death POHYLCK HOU U 500	9 N.C	narles	St. Ba	Hmo	re, HD a	21204 ste.
1	Sta Registra		31. Date (ip Noath, Day, Year) APR 272012 Severa 9.	Signature	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ April Wanda Snyder 26. 10:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 69 Peppermint Lane Baltimore Middle River Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 232 42 4094 1 M 2 X 82 06/19/1929 West Virginia 28a-f shov 10a. State 10b. County must be notified at 10c. City, Town or Location Director Maryland Baltimore Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 69 Peppermint Lane 21220 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Force Black, White, etc. or ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", White 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Printing Company Inspector Be 17. Father's Name (First, Middle, Last) Department of Health and Mental h Important: If item 27 is marked any injury or att. 18. Mother's Name (First, Middle, Maiden Surname) ၉ Russell Graham Bessie Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brent Snyder (son) 10 Flaxleaf Court Essex Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkins Memorial Gardens 4/30/2012 Elkins, West Virginia 21. Si ure of Funeral Service Licepace 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or or heart failure. List complications that clused only one cause on each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final ORONAR disease or condition Medical resulting in death) Due to (or as a consequative of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or in that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decessin the past 12 montr 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) Day detached 9 Unknown 9 Unknown P.O. I à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate h 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending iniury 2 🗌 No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

OV

State Registrar

DHMH 17 Rev 06-2011

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAMPBELL BLUD SUITE 200 BALTIMORE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
#26 Per PHY G926 4/27/2012 JH
State of Maryland / Department of Health and Mental Hygiene Reg. No. 201 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month O'Neil Smith Medical 04 201 5:51 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore My Second Home . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Davs Hours **Director** 1 🖳 M 2 🗆 F 220-07-1827 Usual Residence of Decede 93 05 28 VAshow 10b. County at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f 1 XYes 2 ☐ No Baltimore MD NA 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21217 U.S.A. 2007 Bryant Ave items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces Black, White, etc. 10 à 1 Never Married 2 Married 1 Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 X Widowed 4 ☐ Divorced Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Armid Steel grade Inspector na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allen J. Smith Mary E. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21207 Joseph Smith-Nephew 7032 Yataruba Drive, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) arrison Forest Vet 4/30/2012 Owings Mills, Signature of Janeral Service Licen 22. Name and Address of Facility
March F/H West
4300 Wabash Ave. 6 Raltimore. Md 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate iterval Between Immediate Cause (Final Death Death Physician disease or condition Medical resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-transi The law requires that the death certificate be executed and Due to (or as a consequence of) ding physician Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 I Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has completely filled in by the funeral director, page 2 autopsy performed death? this certificate 1 🗆 Yes 2 No 2 📉 Division of Vital Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Assisted Other: မ 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 28b. Time of Natural 28d. Describe how injury occurred After 5 Pending within 24 hours after death.

To the Funeral Director: A Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medica/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifyling Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. 1 2 4+1 30. Nan e and address o ted cause of death (Item 23a) (Type 31. Date filed (Month, Day, 32. Registrar's S

DHMH 17 Rev 06-2011

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13295 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Smith Physician/ Elizabeth Williams April (2:15 AM 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital of Baltimore Baltimore Sinai Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Min 372 Director 1 M 2 X F 1917 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Baltimore MD Pikesville 1 Yes 2 No 10f. Zip Code 21208 10e. Street and Number 0 10g. Citizen of What Country? must be r Funeral USA 4733 Bonnie Sae items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. ו "natural", or item ledical Examiner ו 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Back 3 ⋈ Widowed 4 □ Divorced Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Give Kind of Work durie Gaining IIII) life. DO NOT use retired) Sales CIERK Elementary/Secondary (0-12) Keed Pharmacy Cotharade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Williams Mamie Best onnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4733 Bonnie Bale Road Pikesville MD 21208 Department of Health ar Important: If item 27 is any injury or other traconce. Daughter (coke 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05 03 2012 Baltimore, MID Baltimore National Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee Vauges C. Koall Bandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ chronic obstructive pulmonary disease 8 Luys Medical resulting in death) Due to (or as a consequence of **Examiner** consestive heart failure diastolic Securitally list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Exam Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by kidney disease stage 3 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes mellitus 24a Was an performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Spec မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident 24 hours after death. Funeral Director; Al Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2

To the F

complete only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signature

ijun Zhon MD . Date filed (Month, Day, Year)

2

address of person who completed cause of death (Item 23a) (Type, Print) hon MD 2401 W Belvedere Ave, Baltimore. MD 2125

D 70334

29d. Date signed (Month, Day, Year) April 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	•		tment of H ficate of D			giene Reg. No.	201	2 13:	296
			Registrar 1. Decedent's Name (First, Middle, Last)			00111	nouto or B	- Catin	2. Date of Dea		201	3. Time of D	
	Physicia Medic		Charlotte Laura S	Schneider					Month 4	1 ^{Day}	2012	2 5:20	Ам
	Examin		4a. Facility Name (if not institution, give st			- 1		Location of Death			ounty of Dea		
9"		5	Hebrew Home of G1 5. Social Security Number 6. Sex		shington		Rockvill If Under 1 Year	e If Under 24 Hrs.	8. Date of Birt		ntgome	rthplace (State or	Foreign
	Funeral Director			M 2X F 93	' '		Months Days	Hours Min.	9-7-18			New Yo	rk
	d d	L	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locat	ion		-			10d. Inside City	
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	or 28 e noti		10e. Street and Number	-1 y	ROCKVI	110	10f. Zip Code			10g. Citize	en of What C	ountry?	
	s 23a nust b	Funeral	1801 E. Jefferson	n St. #414	4		2085	1		Uni	ted St	ates	
	death r item	Fur	11, Marital States	12. Was Decedent Ev Armed Forces?		13. Wa	s Dec e dent of His es, specify Cubar	spanic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	I. Race - Am Black, Wh	erican Indian, te, etc.	
250	s after al", o Exami	d by	1 ☐ Never Married 2 ☐ Married 3 🎞 Widowed 4 ☐ Divorced	1 ☐ Yes 2X☐ N If Yes, Give Year or Dates.	No	1 🗆	☐ Yes 2 🛣 No	Specify:		Sp	pecify:	Vhite	
215-UU36	hour hatur dical	plete	15. Decedent's Edu (Specify only highest grad		16a.	. Deceder	nt's Usual Occupa	tion uring most of work	ina	16b. Kind	d of Busines	s Industry	
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maryland	be fill lental rked c	٩	Samuel Chefetz					Rose Si			,		
az	should and M is ma auma	2	19a. Informant's Name/Relationship (Typ	e, Print)		_		nd Number or Rura					
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saitimore,	nt of h		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	lemoval from State		ry, cremat	tory or other place)	Date		•	r Town, State	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	.0	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			-	Remembra Name and Address	nce 4-18			Goldb	g, Maryla ero	1110
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			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one			not enter t	he mode of dying	, such as cardiac	or respiratory an	rest,		Approximate Interval Between	een
	Ph_ician/		Immediate Cause (Final disease or condition resulting in death)	Asr	irati	on	phe	umon	ia			Onset and De	∌ath
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200	ending use a	M/ne	Zob. Was decedent pregnant	3c. If yes, outcome o	of pregnancy	h 3□E	-ctopic pregnancy	/		23	3d. Date of d	elivery	
X P Q	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Ye	∤ar
л. О	at the	/ Ph	Part II. Other significant conditions con	tributing to death bu	ut not resulting i	in the unc	derlying cause give	en in Part I.	23e. Did to	obacco use	e contribute	o the cause of dea	ath?
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Vital Records,	w requisibles	Completed	Atrial fi	brillat	g'm				24a. Was			utopsy findings av	
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<u>ra</u>	cian: certific ector,	Be	25. Was case referred to medical examiner?	ospital;			26. Pla	ice of Death (Chec					
<u> </u>	Physical this caral direction	ੁ: 10	1 Yes 2 No	1 ☐ Inpatie 28a. Date of injur		Time of	3 DOA 28c. Injury	4-20 Nursing Ho	ome 5 Residence 128d. Describe 1			ecify)	
E E	ath. r: Afte	icate	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day,	(Year) i	injury	work'	? Yes 2□No					
DIVISION OF	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours af er death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		ırm, stree	t, factory, office		28f. Location (S City or Tox		Number or R	ural Route Numbe	r,
בֿ	pital cours at eral D eral D		29a. Certifier 1 Certifying Physic	cian: To the best of r	my knowledge	death on	cured at the time	date and place ar	nd due to the ca	use(s) and	manner as s	tated	
	e Hos n 24 h e Fun bleted	Medical	(Check 2 Medical Examinor only one) 3 Certifying Nurse	er: On the basis of ex	camination and/c	or investig	ation, in my opinio	n, death occurred a	t the time, date a	and place, a	ind due to the	e cause(s) and man	ner stated.
	To the within To the Comp		29b. Signature and title of certifier	1	4	Carl Carl	29c. License	number		29d. Date	signed (Mor	th, Day, Year)	
			Kinda ()	· Janso	n M	$\mathcal{D}_{\underline{}}$	DOC	35/68	7	4/	17/12	7	
i	ن ۷		30. Name and address of person who co	moleted cause of de	eath (Item 23a) ((Type, Prin	6171	Mar	1/10000	RS	R	relieble	mo
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature —			(10)	vou k	J . W.	- 10	208	52
	Registra	ar	APR 2 7 20	12 Dur	v B.	Ma	Res						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ 41 PM Jeanne Lorraine Stiefel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN SQUARE HOSPITA Rosedal 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** (Month, Day, Year) Months Hours Min. Country 215-54-3199 **Director** 1 M 2 XF 52 June 28,1959 Baltimore, Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 0a. State notified at Director Maryland 1 ☐ Yes 2XXNo Baltimore Parkville 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ō er than "natural", or items 23a on the Medical Examiner must be Funeral 8806 Alnwick Road 21234 United States death 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1XXNever Married 2 Married þ Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry بالا be filed المادي. خطا Hygiene. خطا المادية المادي Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Typist 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Otto Conrad Stiefel, Jr. Lorraine Audrey Noyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9605 Alda Drive Carney, Maryland 21234 Betty Cayce (Aunt) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 26 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Evans Funeral Chapel-Bel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Simply of Funeral Service Licensee Name and Address of Name and Address of Facility

Evans Funeral Chapel & Cremation Services—Parkville

8800 Harford Road Parkville, Maryland 21234 rard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death implediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to or as a consequence of if any leading to immedicause. Enter Underlying Exami burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each tours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Pregnant at time of death signed by the aid be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1. Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) iman ao 4-24-12 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, BALTIMORE, 9103 FRANKLIN SQUARE NAMV AO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death irst, Middle, Last) 2. Date of Death Physician/ Medical 4c. County of Death **Examiner** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral Director** 1 MM 2 □ F 5 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Itimore 10g. Citizen of What Country? 10e. Street and Number Funeral 21221 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Ves 2 No
If Yes, Give 1973 -/975
Year or Dates! Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WKIte 3 🗌 Widowed 4 🗌 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) MARYland Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Se huce man 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility - ASLKON 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 1 Yes Medical Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes 1 Inpatient 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 the only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (To Otly Kathryn

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Pleas	e Type or Pri	nt in Black I	ndelible Ink. I	Ensure All Copie	es Are Legible	2 1329
			For State	State of Ma			alth and Mental Hy	ygiene 201	2 1025
			Registrar 1. Decedent's Name (First, Middle, L.	ast)	Ce	rtificate of Dea	2. Date of D	Reg. No.	
	Physicia Medi		61	Mer			Month 04	25 2012	3. Time of Death 6:40A M
	Examir		4a. Facility Name (if not institution, gl		1. 2	4b. City, Town, or Loc		4c. County of Dea	
٨	-		Arc of Central 5. Social Security Number 6.	Chesape	ake Kegion	Sevel If Under 1 Year I If	Lindox 24 May Lo and 450	Anne	Hrunde/
	Funeral Director	ı	500 00 00 00 a	1 M 2 F	(in yrs. last birtifday) Yrs.		Under 24 Hrs. 8. Date of Bi ours Min. (Month, D		rthplace (State or Foreign ountry)
	d d	L	Usual Residence of Decedent 10a. State 10b. County				19/23	3/56	Maryland
	arylan a-f sh ified a	Director		Arunde1	10c. City, Town or Lo		,		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M s or 28 se not	٦	10e. Street and Number	THE GIRGET		10f. Zip Code		10g. Citizen of What C	
	h with 1s 23a nust t	Funeral	7867 Hickory L	eaf Road		21144		U.S	S.A.
	r deat or iten niner r		11. Marital Status 1 ፟፟፟X Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes or No lexican, Puerto Rican, etc.)	14. Race - Am Black, Whi	
036	rs afte rral", c Exarr	ed by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X☐ If Yes, Give Year or Dates.	No	1 ☐ Yes 2X No S	pecify:	0 1/	Thite
21215-0036	within 72 hours after death with the Maryland gene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occupation kind of work done during		16b. Kind of Business	/Industry
7	ed within 7 Hygiene. other than ent, the M	Com	Elementary/Secondary (0-12)	College (1-4 or 5	life F	O NOT use retired) Dependent	gg	Dens	endent
	a th	Be	17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle		indene
<u>⊠</u>	ild be fill Mental narked o	မ	Arthur J	• Soh	mer		E. Wir	nsley	
Maryland	sheam ham 7 is trau		19a. Informant's Name/Relationship				Number or Rural Route Numb		ip Code)
	and Heal tem		Ms. Susan Weisge: 20a. Method of Disposition	rber /Caret	aker 93]	Spa Road	Annapolis,	MD 21401 20c. Location - City or	r Town State
Baltimore,			1 ☐ Burial 2X Cremation 3 l 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	1	natory or other place) Crematory	04/28/2012	Glen Bur	
Salti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice				Facility 1 2nd Aver		
_	0 0 = 0 0	- 1/1	23a. Part 1. Enter the disease, or cor	HOLDON	15	ingleton Fu	ıneral & Crema	tion Servic	
	Physician/		shock, or heart failure. List only Immediate Cause (Final	one cause on each live	ne death. Do not ent			rrest,	Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	MICINE			
	Examiner	<u>.</u>	Sequentially list conditions,	b. ————					
	ed sit	Examiner	if any, leading to immediate E to Thirty Cause (Disease or injury	Due to (or as a	consequence of):				
	executed an and rial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):				
	e be e lysicia ne buri	lical	•	d					
00/90	irtificat ling ph e as ti	/Mec	IF FEMALE:	00-16	,				
XOD	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	Petal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
0	requires that the death certificate be e been signed by the attending physicial should be detached for use as the bur	Physician/Medica	1 Yes 2 No 9 Unknown	9 Unknown					
5	s that gned k	by P	Part II, Other significant conditions				Part I. 23e. Did t	obacco use contribute to	the cause of death?
D S	equire een si	Completed by	CHADNIC HYPERIC	CIARONIC	typerelip	ObmiA,	1 🗆	Yes 2 No 3 P	robably 4 🗆 Unknown
ecords,	has b ge 2 sl	mple	HypoTity ROID 1	CIRRONIC	RENA	FAILUNE	24a. Was	psy prior to	topsy findings available completion of cause of
ř	in: The ificate or, pag		25. Was case referred to medical	NOTE AC		06 Plans	1 \(\text{Yes}		s 24 No
	ysicia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpatier	Other:	of Death (Check only one) Nursing Home 5 Resi	dence 6 MOther (Space	N/A
5	ng Ph fter th uneral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28b. Time of			now injury occurred	
0	ttendi death stor: A / the f	Certificate:	2 Accident Investigation 3 ☐ Suicide 6 ☐ Could not	he l	A h	M 1 Yes			
DIVISION	al or A s after I Direc d in b)		4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office	28f. Location (S City or Tov	Street and Number or Ru vn, State)	ral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying Phy	vsician: To the best of n	ny knowledge, death o	occurred at the time, dat	e and place, and due to the ca	ause(s) and manner as st	ated.
	the H thin 24 the Fi mplets		only one) 3 L Certifying Nui	rse Practitioner: To the	best of my knowledge,	death occurred at the tin	eath occurred at the time, date and place, and due to	the cause(s) and manner a	s stated.
	2 ≥ 2 ⊗		29b. Signature and title of certifier	X //		29c. License num	ber	29d. Date signed (Mont)	i, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

D0060752

Sarch Ashoeck, MD 277 Peninsula Farm Rd. Arnold, MD21012

APR 272012

APR 272012

APR 272012

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7012 Physician/ Month David Shellington 11:15 + Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore **Examiner** Randallstown Season Hospice cial Security Numbe 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth Birthpia Country) MD 9. Birthplace (State or Foreign **Funeral** 212-58-6844 Months Days Hours 4/30/51 **Director** 1 🔀 M 2 🗆 F Yrs 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10b. County 10c. City, Town or Location
Baltimore 10a. State 10d. Inside City Limits Director N/AMD 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 21208 10g. Citizen of What Country? Funeral USA 8 Tentmill Lane-Unit F 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, rmed Forces?

XYes 2 \sum No1 9 7 1 - 7 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. African Specify: Amer þ 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4 or 5+) Fencing Worker 12 Be Father's Name (First, Middle, Last)
Samuel Richardson 18. Mother's Name (First, Middle, Maiden Surname)
Phyllis W. Shellington ൧ 19a. Informant's Name/Relationship (Type, Print) Ella Bessick/ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8023 Mollye Rd, Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balt., MD 4/30/12 1 Burial 2 X Cremation 3 Removal from State Bayview Cremton or other place) 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or semplications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ ATheroscierenz Cardiormscular Distast disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other:
4 Nursing Home 5 Residence 6 Pother Specify There 1 Yes 2 No ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury ☑ Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/24/12

State Registrar

XI

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS (Zyymal/ZeM) Z835 Smih /N 5 Z03

32. Registrar's Signature

00057465

Baltimire MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #19b Per FH G926 4/30/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2320 BM 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home Care Faculty altmare Cet Baltimore 7. Age (In yrs. last birthday) 78 yrs. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 208-22-0534 Months Hours 6/20/3 PA Country) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/ABaltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Funeral 320 N. Hilton St. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc.
African þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates Amer. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 Self College (1-4 or 5+) Auto Mechnic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Talifearro 0 Samuel Lee Simon 19a. Informant's Name/Relationship (Type, Print)
Sheryl Simon/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ellen-Talifearre 320 N. Hilton St. Balto.MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Bayview Crematory 4/26/12 1 Burial 2 Cremation 3 Removal from State Balt., MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt: 21. Signature of Funeral Service Licenses .MD 272665570BA 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset/and Death Physician/ 03/12 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner volled while tiethy first or 1 kills on if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 121 Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe CIDIN OLL ronce 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: At the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co

Registrar

31. Date filed (Month, Day, Year)

7

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2. Registrar's Signature

Dee we-

627

Old

Mulford MM Road

the burial-transi

attending physician I for use as the buris

been signed by the a should be detached

page 2 has

funeral director,

filled in by

After this certificate

24 hours after death Funeral Director:

within 2 To the F

and

7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) title of g 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 🖾 Yes 2 🗆 No

Maryland

4:50 AM

2012

Baltimore

U.S.A.

14. Race - American Indian,

Black, White, etc.

Specify: White

Cosmetology

01

TIMONIUM, MD 21093

Registrar DHMH 17 Hav 06-2011

State

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month. MELVIN E SHULTZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1704 Philadelphia Road Joppa 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. Year 8 Date of Birth **Funeral** Hours Min (Month, Day, Year) 514-26-2888
Usual Residence of Decede Director 1 **X** M 2 □ F 02/06/1931 81 28a-f show must be notified at 10a State 10c. City, Town or Location Director MD Harford Joppa 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? items 23a U.S.A. 1704 Philadelphia Road 21085 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

Yes 2 No Black, White, etc. ō 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Geodesist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked c မ Nellie Calone Booe Melvin William Shultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a Nata Shultz / Wife 1704 Philadelphia Road, Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/26/2012 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Lid 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MULTIPLE MYELOMA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq SEVERE ADRIL STENOSIS 1 Yes 2 No 3 Probably 4 Unknown Records, Completed HEART FAILURE CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral I Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11:30 AM

9. Birthplace (State or Foreign

10d Inside City Limits

Interval Between

Onset and Death

years

Year

Day

death? 1 Yes 2 No

04-26-2012

1 Yes 2 X No

Kansas

White

2012

State Registrar 31. Date filed (Month, Day, Tear)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUNG, 9103 FRANKLIN SOURCE DRIVE # 2200; BALTIMORE MD 21237

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Apri 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5009 Bennett Clarksburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Age (In yrs. last birthday) Date of Birtin (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🛂 53 Yrs Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits arks 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hle 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🖫 No If Yes, Give 3 Widowed 4 Divorced Specify: Year or Dates SIGM 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) tousewite Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Yong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myong 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 25 2012 remator 4 Donation 5 Other (Specify) tanover Sign gf Faneral Service Licensee Facility towell MD 20794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. ANOPLASTIC IG ODENDROGUOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ J Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕊 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the morph after death.

To the Euneral Director After this certificate has F autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 XNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 12 2 ALD 41241

DHMH 17 Rev 7/2009

State Registrar 9707

Medica

31. Date filed (Month, Day, Year)

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20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

/Medi	an	1. Decedent's Name (First, Middle, Las Christologies &	Sengos						6	2. Date of Death		2012 2X	me of Death
Exami	ier	4a. Facility Name (If not institution, give						Location of	Death		4c. Coun	ty of Death	
		Johns Hopkins Bayvie 5. Social Security Number 6. S	ex 7		r last birthday)		more or 1 Year	If Under 2	24 Hrs.	8. Date of Birth		9. Birthplace (S	tate or Forei
Funeral Director		213-69-5412	ĎM 2□F	7		Months		Hours	Min.	(Month, Day, Ye)	(1940	9. Birthplace (S Country) Gre	ece
wc	J - F	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Ins	ide City Lim
a-f sho led at	ţ	MD						Baltin	nore			1 [XYes 2 □ N
or 28.	Director	10e. Street and Number				10f. Zi	p-Code			100	J. Citizen of	What Country?	
is 23a nust b	<u>a</u>	727 Tolna Street	12. Was Deceder	at Ever in III	6 12 1	Non Door	dont of Uli	2122		oif. Voc. or No.	14 Pa	USA	
r iter	E	11. Marital Status1 ☐ Never Married2 ☐ Married	Armed Force	s?					Puerto R	cify Yes or No- ican, etc.)		ace - American Indi ack, White, etc.	a11,
ral", c Exam	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:		1 🗌 Yes		Specify:			Spec	white	
"natu edical	lete	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced	kind of w	ual Occupa ork done d ise retired)	lurina most	of workin	g 16	6b. Kind of	Business/Industry	
r than	Be Completed	Elementary/Secondary (0-12)	College (1-4 c	or 5+)			'	sician				Healthcare	
Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle, Ma		,	
d Men narke natic e	욘	19a. Informant's Name/Relationship	Georgios Sei	ngos	10h Mailir	ag Addre	e /Street	and Numbe	e or Pura		i Anifai	nti n, State, Zip Codel	
Ith and		Eugenia Sengos / Wife				-				, MD 21224	-	n, state, zip coce)	
of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3	Daniel franc Chat	20b. F	Place of Dispo	sition (Na	ame of	9)	Da	ate 20	c. Location	n - City or Town, Sta	ite
ment ta nt: II jury о		4 Donation 5 Other (Specific)	е	Chesape	ake Cı	emator	y		5/2012	I	Beltsville, M	D
Depart Import any In		21. Signature of Funeral Service Licens Dorota Marshall	see	lind	22			s of Facility		ions DO Pa	v 1412	Baltimore, N	4D 2120
ician and burial-transit	9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence		<u>s</u> m							
ttending phys for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1	n 2 ☐ Feta t at time of do	l death 3 ceath 5 ceath	Other (s	, ,,			22a Did taha	N	Date of delivery Month Day	Year
<u> </u>	6	Take in Surface Significant Solidations of		T but not res			y cause giv	ren in i ait i		1 Yes		3 Probably	2
n signed b	Completed									24a. Was an autopsy performe		b. Were autopsy fin prior to completic death? 1 🗌 Yes 2 🗀 N	on of cause
ate has been signed by the a page 2 should be detached	ŏ.	25. Was case referred to medical examiner?	Hospital:	ations OF#	ER/Outpatien		Othe			(Check only one)		When 20 and 11 h	
ate has page 2	Be	1 Yes 2 W No		njury	28b. Time o		28c. Injury Work	at		e 5 Residence 8d. Describe how			
this certificate has ral director, page 2	To Be	1 ☐ Yes 2 🕱 No 27. Manner of Death	28a. Date of Ir	Jay Icai,	Injury	М	1 🗆 \	: ∕es 2 🗀 N		8f. Location (Stre		mber or Rural Rout	
er this certificate has neral director, page 2	To Be		(Month, L	injury - At ho etc. <i>(Specif</i>)		eet, factor	y, onice			City or Town,	State)		e Number,
er this certificate has neral director, page 2	To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (check only) 27 Medical Exar	28e. Place of building, ysiclan: To the besinner: On the basis	etc. (Specify st of my know of examinat	v) wledge, death	occurre	d at the tim	ne, date and	d place, a	nd due to the cau	use(s) and i	manner as stated.	
er this certificate has neral director, page 2	edical Certification: To Be	27. Manner of Death 1 M Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 29a. Certifier 27. Manner of Death 5 □ Pending investigatior 6 □ Could not b determined	28e. Place of building,	etc. (Specify st of my know of examinat	v) wledge, death	occurred vestigatio	d at the tim	pinion, dea	d place, a	nd due to the cau ed at the time, da	use(s) and i te and plac	manner as stated. ee, and due to the de-	ause(s)
this certificate has ral director, page 2	To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (check only one) 27. Manner of Death 5 Pending investigatior 6 Could not b determined	28e. Place of building, ysiclan: To the besinner: On the basis	etc. (Specify st of my know of examinat	v) wledge, death	occurred vestigatio	d at the tim	pinion, dea	d place, a	nd due to the cau	use(s) and i te and plac	e, and due to the o	ause(s)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lewis Stewart Spar	1- For State	State of Maryla	and / Department of Certificate of		Mental H		2	012 1331
Physician/	Registrar 1. Decedent's Name (First, M	iddle,Last)				2. Date of Deat		3. Time of Death
Medical Examiner	Lewis Stewart	Sparrew,				Month April 20, 20		2214 hrs
	4a. Facility Name (if not instit 1502 Frederick Roa		imber)	4b. City, Town, or Lo Catonsville	ocation of Death		4c. County of Baltimore	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs	. 8. Date of Birt		9. Birthplace (State or
Director	220-22-7230	1XM 2F	81Yrs	Months Davs	Hours Min	_	,	Foreign CountMaryland
	Usual Residence of Deceden					nag.	,1750	rai y raiiu
any	10a, State 10b. Coul	,	10c. City, Town or Locati	ion				10d. Inside City Limits
f sho	Maryland Balt	imore	Catonsville					1 Yes 2 X No
n or 28a-f sh lifted at once Director	10e. Street and Number 912 South Rol	ling Pond /	\n+ #301	10f. Zip Code 21228			g. Citizen of Wha nited St	•
r death with the Maryland or items 23s or 25s-f show must be notified at once. Funeral Director				s Decedent of Hispa	ania Origin2 / Sr			American Indian, Black,
r death with or items 23 : must be no	1 Never Married 2			es, specify Cuban, I			White,	
s after d	3 E Widowed 4	Divorced If Yes, Give Yea	1 🗆	Yes 2 No	s <i>pecify</i> :		Specify:	White
hours :	15. Decedent's Education (S	pecify only highest grad	during me	t's Usual Occupation ost of working life. D			16b. Kind of Busi	ness/Industry
36 in 72 han ", dical 1	Elementary/Secondary (0-	2) College (1	-4 or 5+) Self En				Contract	or
21215-0036 Juld be filed within 72 hour Mental Hygiene. marked other than "matu te event, the Medical Exau To Be Completed	17. Father's Name (First, Mid	dle, Last)		• •	.Mother's Name	(First, Middle, M	laiden Surname)	
215 be file mtal H rked o		•		I:	rma Voll	cert		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 37 is marked other than "natural", or items 33a or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relation		4	Address (Street a				
MD alth and 2 sho saith and 2 is raumati	Jane Sparrow 20a. Method of Disposition	/ Daughter	5530 I 20b. Place of Disposi	Highridge	St., Ha	alethorp	e,Maryla	nd 21227 ity or Town, State
Baltimore, permit. Pages I as Department of Hei Important: If ite	1 X Burial 2 Crema	tion 3 Removal fro	crematory or oth	ner place)				e, Maryland
tim Pagitturent refant:	4 Donation 5 Other 21. Signature of Funeral Serv							
Bal Deemi Mijur	21. Signature of Full letal Selv	Rug-	X .	ame and Address o				NC. ryland 21227
Physician	23a. Part I. Enter the disease	or complications that ca	aused the death. Do not enter the	ne mode of dying, su	ich as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval
/Medical £xaminer	failure. List only one cau Immediate Cause (Final disea	11.	ve Atherosclerotic Cardi	ovascular Dise	ase			Between Onset and Death
_Adminer	or condition resulting in death) Due to (or as a	consequence of):					
6	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					_
red Insit Examiner	cause. Enter Underlying Cau (Disease or injury that initiate	se c			_			14]
L Exa	events resulting in death) La		consequence of):					
be executed ician and urial - transit	UNPENDED	AMENDED						
cast 68760, eath certificate be saftending physic for use as the burnsican/Med	IF FEMALE:	23c. If yes, c	outcome of pregnancy				23d. Date of de	elivery
687 certifu	23b. Was decedent pregnant in past 12 months?	I I Live Di		al death 3	Ectopic pregna	ncy	Month	Day Year
). Box 68760 the death certificate by the attending physiched for use as the burnhysician/Me	1 Yes 2 No 9 1	Jnknown 9 Unkno	3 Ott	ner (Specify)				
P.O. Boy that the death ned by the att detached for by Physi		ditions contributing to	death but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactory after the result of the funeral director.	Diabetes Mellitus					1 Yes		Probably 4 V Unknown
tal Records, cian: The law requires certificate has been sig ector, page 2 should be Be Completed						24a. Was ai autops	y prio	re autopsy findings available or to completion of cause of
Rec The la cate h						perform		ith? ✔ Yes 2 No
Ital Reician: The certificate rector, page	25. Was case referred to med examiner?	Hespitel:			Death (Check o			
of Vi Physical er this	1 ✓ Yes 2 No 27. Manner of Death		patient 2 ER/Outpatient of Injury 28b. Time of In				Residence 6	
on of anding Ph. th. r: After t te funeral	1 M Notural	28a. Date of (Month, ending	Dey,Year)	1 Yes		204. 2000 150 110	ow injury coccined	
/isior r Attend ter death irector: n by the		vestigation 28e. Place	of Injury - At home, farm, stree	t, factory, office buil	ding, etc.			or Rural Route Number, City
Division or strending septial or Attending hours after death hours all the form of y filled in by the fune Certification:	Galoido	termined (Specify)				or Town, Sta	ate)	
24 7 H	(0.00000 00.00)		t of my knowledge, death occurr f examination and/or investigati					
To the within To the comple	29b. Signature and title of cert	and manner st	ated.	29c. License n	number	I	29d. Date signed	(Month, Day, Year)
	1 / clork	MU		O.C.M.	E.		April 21, 201	2
11	30. Name and address of pers		'	ltimore Ctract	Daltima	4D 24222		
State	Laron Locke MD. 31. Date filed (Month, Day, Yea	A	Examiner 900 W. Ba		————————	111 Z 1223		
Registrar		7 2012	wa S. par	les .				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 11.994 317 4:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death CONTER HUNE A RUNOle If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 220-24-6826 Min **Director** 1 🗆 M 2 😾 F 81 Yrs. June 25,1930 Maryland show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Anne Arundel
10e. Street and Number Glen Burnie 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21061 Glenwood Ave. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc Completed by 1 Never Married 2 Married 72 hours after 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 🕅 Widowed 4 🗆 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker $12 \pm h$ marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Cora Mae Tucker Howard E. Bentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 412 Glenwood Ave., Glen Burnie, Maryland 21061 Donald Storm / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Prk. Apr. 26,2012E1kridge, Maryland 21. Signati e of Funeral 22. Name and Address of AMBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ SEPTIC SHOCK VAQ 1 disease or condition Medical resulting in death) Due to (or Examiner DANGE SABJOUL 2440 E Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Day Year Pregnant at time of death Unknown by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, CAD, DM, CKD Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be director, page 2 s autopsy 1 ☐ Yes 2 🛂 No 1 X Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No of thours after death.

E Funeral Director: After the full betely filled in by the full ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 ho

To the Fune

completely f

CUILLERMO JOSÉ GIANGRECO 301 HOSPITAL DRIVE, GLEN BURNIG, MD 21061 31. Date filed (Month; Day, State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mc was given day word into

DHMH 17 Rev 06-2011

29a. Certifier

3 🗀

29b. Signature and title of certifier

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D00e5±14

29d. Date signed (Month. Dav. Year)

Y6816 51, 5015

12-02989 Patrick Toney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 13309 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** April 16, 2012 1637 hrs Patrick Ra

4a. Facility Name (if not institution, give street and number Rapheal Toney 4b. City, Town, or Location of Death c. County of Death **Baltimore Washington Medical Center** Glen Burnie Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Min. Hours Director 1.0 11 70 587-19-1024 41 Country) 1 X M 2 F Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Anne Arundel MD Odenton Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho notified at once, 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U.S.A. 8710 Aspen Grove Ct. 21113 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 XMarried 1X Yes f Yes, Give Yeer 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: Black 줊 il Hygiene. ed other than "natural t, the Medical Examin 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Bowie State Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** 12th grade 5+yrs Academic Advisor University 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Canslor Robert Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya M. Toney-Wife 8710 Aspen Grove Ct., Odenton, Md 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify King Memorial Park 4/28/2012 Woodlawn, Md 21. Signature of Funeral Service Li 22 Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Complications of Excited Delirium associated with synthetic Marjuana use following police arrest and a Restraint Procedures. Approximate Interval **Physician** Between Onset and /Medical Death Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate account. Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g928 6-4-12 sm X UNPENDED signed by the attending physician be detached for use as the burial Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 百 1 Yes 2 No 3 Probably 4 V Unknown cardiomegaly with four Chamber Dilation Completed After this certificate has been sfuneral director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: DOA 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural unknown Director: / 1 Yes 2 X No 5 Pending fd 07:50 pm fd 4-13-12 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State Piney Branch Pkwy & Odenton Rd. Odenton, MD. 3 Suicide 6 X Could not be (Specify) Street determined Homicide 29a. Certifier (Check only completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 18, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

			For State Registrar	State of Marylar	nd / Dep		Health and N	Mental Hyg	iene		13310
ı	Physicia Medi		Decedent's Name (First, Middle, Last) Joseph	Tubiolo		inouto or i		2. Date of Dea Month April	-	ž ^e ar ₂	3. Time of Death
	Examir		4a. Facility Name (if not institution, give str Charlotte Hall Ven		2		r Location of Death		4c. County	of Death Mary	
1	Funeral Director		090-10-0020 3-	M 2 □ F 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 18	Year) 1927	g. Birthpl Counti New	ace (State or Foreign Y) York
	he Maryland or 28a-f show s notified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Montgon		y, Town or Lo		er Spring			10	0d. Inside City Limits 1 ☐ Yes 2 X No
	ith the M 23a or 28 st be not	Funeral Director	10e. Street and Number 1001 N. Mansion I)r		10f. Zip Code	20910		Og. Citizen of V		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.	출		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 1944-			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	e - America k, White, e	n Indian, tc.
Maryland 21215-0036	ithin 72 hour ene. • than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	ation	16a. Dece (Give life. D	dent's Usual Occup kind of work done (O NOT use retired)	during most of work	ing	16b. Kind of Bu		ustry
/land 2	d be filed w Wental Hygi arked other atic event, t	00	17. Father's Name (First, Middle, Last) Justin	Tubiolo	Litero	preneur	18. Mother's Nam France				ato
, Mar	nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relationship (Type Lucy Madert / Daug				and Number or Run				^{ode)} 20910
Baltimore,	Page 1 al ment of H tant: If itel jury or oth		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	anaval from State	emeterv, crer	sition (Name of natory or other place ce Cremat	ce) i	Date 5/2012	20c. Location - Be1tsv		
Balt	permit Depart Impor any inj once.		21. Signature of Funeral Service Licensee		_ 9	33 Gist	raT ^{ac} and C Ave., Sil	ver Spri	ng, MD	es 209	910
C	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one dimmediate Cause (Final disease or condition resulting in death)	cause on each line	one.		g, such as cardiac			20	Approximate Interval Between Inset and Death
46		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	Due to (or as a consequ	Janea Crj.						
8 00	ate be executed ohysician and the burial-transit	g	resulting in death) Last	Due to (or as a consequ	uence of):						
. Box 6876	Hospital or Attending Physician: The law requires that the death certificate it at hours after death. 44 hours after death. Funeral Director, After this certificate has been signed by the attending physited filled in by the funeral director, page 2 should be detached for use as the		F FEMALE: 23c. Was decedent pregnant in the past 12 months? 1 \(\triangle \	lf yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	aldeath 3	Ectopic pregnanc Other (specify)	;y		23d. Dati Mor	e of deliver	y Day Year
ls, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions control	ibuting to death but not res	ulting in the u	nderlying cause giv	ven in Part I.			_	cause of death?
Records,	The law req ate has bee page 2 sho	Completed by	Hypor tensin	i Demiz	neso	sofhe		24a. Was ar autops perforr 1 \sum Yes	y p ned? d	/ere autops rior to com eath?	y findings available pletion of cause of
ital	ysician: The la nis certificate ha director, page?	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:		Oth	ace of Death (Checi	k only one)			
of V	g Phys er this eral dii	은: :e:	27. Manner of Death	1 Inpatient 2	28b. Time of	t 3 □ DOA 28c. Injury	4 Nursing Hoy at	ome 5 Reside			
on	tending I eath. or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 🗆	Yes 2 No				
Division of Vital	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	al Cert	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)			28f. Location (Str City or Town	State)		
	the Hosp hin 24 ho the Fune Inpleted f	Medical	(Check 2 Medical Examiner	an: To the best of my knowl On the basis of examination ractioner: To the best of my	and/or invest	igation, in my opinic	on, death occurred at	the time, date and	place, and due	to the caus	e(s) and manner stated.
	To t		29b. Signature and title of perfitting	3		29c. License	37-22	8mo.	d. Date signed	(Month, Da	19, Year) 23, 2012
	6x,		30. Name and address of person who dom Stephen P. Caffert	y, D.O., 223	333 Gre	enview P	kwy. #5,	Great Mi	lls, MI) 20	0634
	Stat Registra		1. Date filed (Month, Day, Year)	32. registrar's Signat	1. 6	ales					

12-02799 Jan Douglas Tuckley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 13311

		1- For State Registrar		Cei	rtificate of	f Death			F	Reg. No.		
Physicia dical Exami	an/	Decedent's Name (First, Middle Jan Douglas	Tuckley						2. Date of Dea Month April 9, 20	Day 012	Year	3. Time of Death 1641 hrs
		4a. Facility Name (if not institutio Val Summit Road				4b. City, Tow Clarysvi	ille	cation of Dea		All	County of Death egany	
Funeral Director		5. Social Security Number 191-44-6513	6. Sex 7. A	Age (In yrs. I	last birthday) Yrs		Days	If Under 24H Hours M	_	,	Foreig	thplace (State or gn puntry) unk
und show any	5	Usual Residence of Decedent 10a. State 10b. County Mine	eral County		, Town or Locati	ion						10d. Inside City Limits 1 Yes 2 XNo
ith the Maryland 23a or 28a-f show notified at once.	l Director	10e. Street and Number RR 4 Box 170 F	ζ			10f. Zip Co				10g. Citize	n of What Cou	ntry?
er death with the	Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divi	1 X Yes	es?	If Y	es, specify C	uban, M	lexican, Puer	Specify Yes or No to Rican, etc.)	White, etc.		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	eted by	15. Decedent's Education (Spec Elementary/Secondary (0-12)	orced If Yes, Give Year 1 (or Dates: cify only highest grade c	completed)	16a. Deceden during m	nost of workin	cupation	(Give kind o			pecify: W nd of Business/I	
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medics	Completed	17. Father's Name (First, Middle,	4yrs		Disa	abled	18.	Mother's Nan	ne (First, Middle,		isabled	<u> </u>
21215-00 buld be filed with Mental Hygien marked other ic event, the M	o Be (David Tuckley 19a. Informant's Name/Relationsl	Fig. (T. res. Deint.)		Lage Maille	- 4 4 4 /			a Ruth I			71 6 11
MD 2 d 2 shoul lth and M a 27 is m	Ĕ	Kermit L Burch		Agent	910 R	Rutgers	s Dr	ive Al	lison Pa	ark P	A 15101	
Baltimore, MD Z permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is in jury or other traumatic		4 Donation 5 Other Sp		State	Place of Dispos crematory or oth lantic	her place) Crem		04	Date /20/12	Gle	cation - City or en Burn	ie MD
Balt permit Depart Impor injury		21. Signature of Funeral Service	Lipensee						mplicity O Ridge			Serv MD 21076
Physician /Medical £xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. a. Multiple Injurie	es		he mode of d	lying, suc	ch as cardiac	or respiratory an	rest, shock	, or heart	Approximate Interval Between Onset and Death
f		or condition resulting in death) Sequentially list conditions,	Due to (or as a corb.	isequence o	л): 							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cor									
ecuted and transit		events resulting in death) Last	Due to (or as a cor	isequence o	ч).							
760, icate be executed physician and the burial - transit	Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outo	come of prea	nancy					I 23d.	Date of delivery	,
Box 687 e death certifice the attending p ed for use as th	Physician/I	23b. Was decedent pregnant in th past 12 months?	e 1 Live birth	at time of de	2 Feb	etal death ther (S <i>pecify)</i>		Ectopic preg	nancy			Day Year
i, P.O. I ires that the signed by the 1 be detached	by	Part ii. Other significant conditi	ions contributing to de	ath but not re	esulting in the u	inderlying ca	use give	n in Part I.			e contribute to	the cause of death?
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed						<u> </u>		24a, Was auto perfo 1 Yes	psy orm <u>ed</u> ?		stopsy findings available completion of cause of the second No.
fital Rec sician: The is certificate lirector, page	Be	25. Was case referred to medical examiner?	Hospital:	atient 2	ER/Outpatient			Death (Chec	k only one) sing Home 5	Residenc	e 6 🗸 Other	Scene
on of Virending Physicath. or: After this the funeral dir	ıtion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of Ir	njury y,Year)	28b. Time of In FOUND: 1634 hrs	Injury 28c	. Injury a		28d. Describe Subject jum	how injury		
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fil	Certification	3 Suicide 6 Could 4 Homicide		Injury - At ho	ome, farm, stree	et, factory, of	fice build	ding, etc.	28f. Location (or Town, S Val Summit F	State)		ral Route Number, City
To the Hos within 24 h To the Fun completely	Medical		nysician: To the best of miner:On the basis of ex and manner state	xamination a								
H 3 F 8	Me	29b. Signature and title of certifie		<u>u.</u>			icense n				te signed <i>(Mor</i>	nth, Day, Year)
51		30. Name and address of person Ana Rubio MD. Ass	who completed cause o	,	,	imore Stre	eet, Ba	altimore, M	/ID 21223	1		
St Regist			32. Regist	irar's Sinati	urebacke	/						

12-03227 William Joseph	Tom	er State of Maryland / D					ible.	
william Joseph		1- For State	•	e of Death	iu ivientai ny	_	No. 201	2 133
Physicia		Registrar 1. Decedent's Name (First, Middle,Last) William Jos			· · · · · · · · · · · · · · · · · · ·	2. Date of Death	J. NO. L O I	3. Time of Death
Medical Exami		William Joseph Toner				Month April 25, 20	Day Year 112	1623 hrs
		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Deat	
		3705 Redberry Way	last bidba	Nottingham		To Date of Birth	Baltimore Cou	,
Funeral Director			yrs. last birthda	Months Day		1	(MM/DD/YYYY) 9. Bir Foreig	an
		212-90-1792 1 M 2 F 40 Usual Residence of Decedent		Yrs.		March 18	, 1972	untry)Maryland
any			City, Town or	Location				10d. Inside City Limits
	5	Maryland Baltimore N	Notting	ham				1 Yes 2 No
Varyland 28a-f show	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	ntry?
n the h		3705 Redberry Way		21236		1	United Sta	tes
th with with the man 2	unera	11. Marital Status 1 Never Married 2 Married Armed Forces?	in U.S.	Was Decedent of Hi If Yes, specify Cuba			14. Race - Amer White, etc.	ican Indian, Black,
er dea	큔	1 Yes 2 X	No	1 Yes 2 X No	specific		Specify: Whi	te
urs aft tural'	ह	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Dec	cedent's Usual Occupa	tion (Give kind of w		16b. Kind of Business/	
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ring most of working life		ed)		
Medic Medic	티	12	E	Business Ow			Self Empl	oyed
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) George J. Toner, Jr.			18.Mother's Name Nancy L.	•	•	
212 ould be Menta mark	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Stree				, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner mast be notified at once.		George J. Toner, Jr. (Father	r) 88	317 Alnwick	Road Par	kville,	Maryland :	21234
Te, I and I and I tem		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		Disposition (Name of ce			20c. Location - City or	Town, State
Pages lent of				od Cemetery		il 28,	Parkville	, Maryland
Baltimore, permit. Pages 1 at Department of He Important: If ite		21. Signature of Funeral Service Licensee		22. Name and Addres	s of Facility		on Consison I	ordari llo
		23a. Part I. Enter the dise se, or complications that caused the d	leath Do not o	8800 Ham	ford Road P	arkville.	on Services I Maryland 212	Approximate Interval
Physician /Medical		failure. List only on cause on each line.			, such as calculac of	respiratory arres	it, Shock, of Healt	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot W Due to (or as a consequer		ead				
	J	Sequentially list conditions, b						
	흘	if any, leading to immediate Due to (or as a consequer cause. Enter Underlying Cause	ice of):					
bit sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	nce of):					E 25
executed an and al - transit	Sa	d. UNPENDED X AMENDED #1, per	me,g9	28 6-15-12	sm			
60, ate be ohysici	an/Med	IF FEMALE: 23c. If yes, outcome of	pregnancy		· · · · · · · · · · · · · · · · · · ·		23d. Date of delivery	,
OX 68760, rath certificate be ex attending physician for use as the bunial.	jan/	23b. Was decedent pregnant in the past 12 months?	of death	Fetal death 3	Ectopic pregnar	ncy	Month [Day Year
Sox death of attent for us	hysicia	1 Yes 2 No 9 Unknown 9 Unknown	or death 5	Other (Specify)				
rds, P.O. Be requires that the de been signed by the hould be detached f	<u>~</u>	Part II. Other significant conditions contributing to death but	not resulting in	the underlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ires th	ğ ğ					1 Yes	2 No 3 Prob	ably 4 Unknown
ords, w requir	Completed					24a. Was an autopsy		topsy findings available completion of cause of
Recol	Ē					perform		s 2 No
Vital Rec yrician: The I his certificate I	8	25. Was case referred to medical examiner?		26.Place	of Death (Check o	nly one)		
Physic Physic al dire	0	1 Yes 2 No		atient 3 DOA			esidence 6 🗸 Other	: Scene
n of hiding Ph.	ᇹ	27. Manner of Death 1 Natural 5 Pending FOUND: Day, Year)	FOUND			Subject shot	w injury occurred self	
isio Atter rector by the	<u>g</u>	2 Accident Investigation Apr 25, 2012	At home, farm	rs , street, factory, office t		28f, Location (Str	eet and Number or Ru	ral Route Number, City
ital or led in	Certification:	3 ✓ Suicide 6 Could not be determined (Specify) Single				or Town, Sta 3705 Redberry	te) Way , Nottingham, l	MD
Hosp 24 hou Funce		29a. Certifier 1 Certifying Physician: To the best of my kno	wledge, death	occurred at the time, d	ate and place, and	due to the cause(s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buil	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	ion and/or inve					
	Σ	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Moi	nth, Day, Year)
─ ,		Totalla- Mele		0.C.	IVI, ⊑.		April 26, 2012 	
13x		 Name and address of person who completed cause of death Patricia Aronica-Pollak MD. Assistant Medic 		er 900 W. Baltir	more Street, Ba	altimore, MD	21223	9
4	ate	31. Date find (Month 2012) Level 32. Registry's Sig		<i>j</i>				
Regist	rar	APR & 1 2012 Lenera B.	gare					

OCME

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 4 Physician/ 8 Helen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** BALTO. OAKCREST ASST. LIVING PARKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 212-18-5299 1 D M 2 X F Director JUNE 20,1921 MARYLAND 90 Usual Residence of Dec 10a. State 10b County 10c. City, Town or Location at 10d. Inside City Limits the Maryland **Funeral Director** notified 28a-f MD. BALTO. PARKVILLE 1 Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò must be 23a **UNIT 227** USA 8830 WALTHER BLVD. 21234 items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ò ō 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify WHITE "natural", Completed 3 X Widowed 4 Divorced Year or Dates th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARY WHELAN BERNARD LAVERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau SON 5 PERHALL COURT NOTTINGHAM, MD. 21236 JOSEPH TEWEY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL 4-26,2012 BALTIMORE, MD. 21. Signature of Funer I Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERALHOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD.21236 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart famore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cuke Myocardial disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir use as the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has be autopsy performe Yes 2 No 2 No Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 힏 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 🛣 Natural 5 Pending
Investigation 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H0052365 4-23-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rongil Jeffreys 8800 Walthar Bl

Registrar

State

Ronald

31. Date filed (Month, Day, Year)

APR 2

8800 Walther Blue

Registrar's Signature

Parkville, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 State DYPMGR76hd / Bepartment of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 21, 2012 TREIBER MYRA 3:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOMERFORD PLACE FREDERICK FREDERICK 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Director 216-30-0388 1 □ M 2 🗓 F 08/13/1931 80 MD show or 28a-f show notified at 10a. State 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No MD FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 7300 BROOKSIDE DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other the SPOKESPERSON BOARD OF EDUCATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ STANLEY SPECTRE RITA FLEHINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 GLENN TREIBER/HUSBAND 7300 BROOKSIDE DRIVE, FREDERICK, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of
Important: If if
any injury or o 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONGR. 04/23/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Mint Medical Examiner Microcytic Arenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy

Live Birth 2 Petal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 2 046248 112 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha Jane Pierce Somerford Place Frederick, Md 21702

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

10d. Inside City Limits 1 🗆 Yes 2 🕅 No 10g. Citizen of What Country' U.S.A.

WHITE

Approximate Onset and Death

Year

Birthplace (State or Foreign Country)

BALTIMORE

MARYLAND

14. Race - American Indian,

Black, White, etc.

20c. Location - City or Town, State

Specify:

10:05PM

16b. Kind of Business/Industry HAUS TAILORING

Reg. No.

2012

18. Mother's Name (First, Middle, Maiden Surname) MARY AVERELLA

19a. Informant's Name/Relationship (Type, Print) PAUL A. TIBURZI/SON

9b. Mailing Address (Street and Number or Rural Route Number, City 14 COUNTRY CLUB LANE PHOÉNIX, MD

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 X Burial 2 Cremation 3 Removal from State SACRED HEART JESUS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee

5-1-12 DUNDALK, MD 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21237

1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final

resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Underlying that initiated events

disease or condition

Due to (or as a consequence of)

COLON GANCER

Due to (or as a consequence of)

Due to (or as a consequence of)

resulting in death) Last

1 Unknown

1 ☐ Yes 2 X No

5 Pending

27. Manner of Death

X Natural

29a. Certifier

(Check

Accident

APR 2 7 2012

IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

Pregnant at time of death g Unknown

23d. Date of delivery Month Day

perform

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death? Νo

3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

death?

Location (Street and Number or Rural Route Number, City or Town, State)

Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE

28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Yes 2 No

Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occ

urred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

npleted cause of death (Item 23a) (Type, Print)

TRACIE L. MORGAN. 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year 32. Registr

State Registrar

DHMH 17 Rev 06-2011

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2012

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and is m

Department of Health a Important: If item 27 is any injury or other traconce.

Physician/

Medical

Examiner

burial-transit

as the l attending)

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signed by the ar

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page 2

director,

filled in by the funeral

After this certificate has

al or Attending Physician: The safter death.

To the Hospital o within 24 hours aff To the Funeral Di

physician

Records, P.O. Box 68760

Division of Vital

ANGELA TIBURZI

Examiner

Physician/Medical

Completed by

Be

ပ္

Certificate:

Medical

Page .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Year April 21, 8:15 P. M Laura Jean Urbani Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Harford 1809 Bayonne Court Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 430-66-9206 73 1 M 2 X F Jan. 18, 1939 Tennessee Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral with USA 1809 Bayonne Court 21015 death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Yes Yes, Give 2 X No 1 Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Winfield McKenzie Jr. Ina Eileen Priest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai once. 1809 Bayonne Court, Bel Air, Maryland, 21015 Donald L. Urbani Sr. / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem. Unknown Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licen 21. Signature 22. Name and Address of Facility McComas Funeral Home, P.A. 9 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE PARKINSON'S DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 been signed by the attending IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death LAURA URBANI 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Year Pregnant at time of death Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Ves 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital Other 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🗶 Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending injury 2 Accident M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

only one) 29b. Signature and title o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN CRNP

2300 DULANEY VALLEY RD. 32. Regist

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM,

MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 19 Day 2012 Beverly W. Vitarelli 10:45A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) 278-34-2603 **Director** 1 □ M 2 💢 F 73 June 8, 1938 Ohio Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 1 Tes 2 X No Maryland| Montgomery Kensington 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 4815 Flanders Avenue 20895 United States "natural", or items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 No 1957-Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Nidowed 4 Divorced Completed 1958 White . Page 1 and 2 should be filed within 72 hours tment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) House of Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Representatives Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James R. Wiand, Sr. Thora M. Porcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Vitarelli/Husband 4815 Flanders Avenue, Kensington, MD 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State April 27, Montgomery Crematorium, 4 Sonation 5 Other (Specify) Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Tome/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Juneral Service Licens Rockville; M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Examiner Sequentially list conditions, it any leading to inviscost cause. Enter Underlying Examiner Due to (dras a persecutional of Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months? ę Pregnant at time of death page 2 should be detached Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2. N 1 Yes the Hospital or Attending Physician: hin 24 hours after death. filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 - No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of sertifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wishous 1300 CHEUX CHASE, MD 20815

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	nd / Department of Health and Mental Hygiene
			_ State Registrar	Certificate of Death Reg. No. 2012 13318
H	Physicia Medi		1. Decedent's Name (First, Middle, Last) DONALD M, WIC	CKERSHAM And 25 20 12 6 15 p.M
	Examir	ner	4a. Facility Name (if not institution, give street and number) Northwest Medical Center	4b. City, Town, or Location of Death Randallstown 4c. County of Death Baltimore
	Funeral Director	Г	5. Social Security Number 6. Sex 7. Age (In yrs. Ia: 189–40–9240 1 ☑ M 2 ☐ F	Months Days Hours Min. (Month, Day, Year) Country)
			Usual Residence of Decedent 62	V. Town or Location Dec. 5, 1949 Pennsylvania
	//anylan/8a-f sh tified a	Funeral Director		y, Town or Location 10d. Inside City Limits Catonsville 1 □ Yes 2 ☒ No
	th the N 3a or 2 t be no	a Dii	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	ath wi	nuel	6108 Collinsway Road 11. Marital Status 12. Was Decedent Ever in U.S.	21228 USA
920	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by F	1 Never Married 2 Married 3 Widowed 4 X Divorced Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 x No Specify: Specify: White
21215-0036	רסטן 72 hour. an "natu Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry
	withir giene ner tha t, the		Elementary/Secondary (0-12) College (1-4 or 5+)	Warehouse Manager Automobile
Maryland	be filed ental Hy ked otl ic even	To Be	17. Father's Name (First, Middle, Last) Joseph Thomas Wickersham	18. Mother's Name (First, Middle, Maiden Surname) Kathryn Hollenbach
ary	should and Ma is mar	13	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 s Health em 27 ther tr		Barbara Lynn Jones Partner 20a. Method of Disposition	6108 Collinsway Road; Catonsville, MD 21228 Place of Disposition (Name of 20c. Location - City or Town, State
Baltimore,	Page 1 ment of ant: If it		1 - 34	emetery crematory or other place) antic Crematory 4/28/2012 Glen Burnie, MD
Balt	permit, Page Department of Important: If any injury or once,		21. Signature of Funeral S ry te Licensee	22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228
E			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	Medical	P 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence)	Se mg Onset and Death
	Examiner	<u>_</u>	Sequentially list conditions, b.	
	ted	Examiner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Gause (Disease of Injury	uence of):
	tte be executed hysician and the burial-transit		that initiated events c. Due to (or as a consequence of the constant of the co	uence of):
260	cate be physic the b	ledical	d	
Box 687	or Attending Physician: The law requires that the death certificate be executed affect death. Affect that this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	al death 3 Ectopic pregnancy
, P.O.	es that the dea signed by the a I be detached I	by	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown
Records,	w require s been signal	Completed		24a. Was an 24b. Were autopsy findings available
Rec	The law cate has page 2:	Com		autopsy prior to completion of cause of death? 1 □ Yes 2 □ No
of Vital	ysician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpution 2 To 1	26. Place of Death (Check only one)
of	ng Phys fter this uneral d			ER/Outpatient 3 DOA Other Specifi 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred
Division	al or Attending P s after death. I Director: After the d in by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 🗆 Yes 2 🗆 No ome, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Divi	ital or / Irs after raf Dire		building, etc. (Specify)	City or Town, State)
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check 2 Medical Examiner: On the basis of examination	edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. n and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Vith vith		29b. Signature and title of certifier	29c. License number 29d Date signed (Month, Day, Year)
	2.1		30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)
	∬ V Stat	te .	31, Date filed (Month, Day, Year) 32/Registrar's Signatu	Aurish'n Olver Ster BIRMP21061
i i	Registra		APR 2 7 2012	9. parle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 100 PM ichard April L. Whaley Jr. 26 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 🗆 F Months Days Hours Min 51 Jan. 27, 1961 **Director** MD 213-82-1328 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f sho ner must be notified at MD Baltimore 1 Yes 2X No Director Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7114 Gough Street 21224 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iten edical Examiner Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo White کر م If Yes, Give Specify: Specify: 3 Widowed 4 Nivorced Year or Dates: Completed other than "natury vent, the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cook 12th 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) th and Mental H
?7 is marked otl
traumatic even Be Richard L. Whaley Sr. Joan Watkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Whaley Sr. /father 7114 Gough Street Balto. MD 21224 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 4/30/12 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Inlury or ot once. 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral S ce Licenses Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final End stage 11
Due to (or as a conse vence of): Physician liver disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the control of the contro Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last iding physician and use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 No detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Id be de þ Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an .te has h , page ? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Anpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 4 5 Pending investigation Injury 1 M Natural 1 Yes 2 No death. Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide after City or Town, State) within 24 hours a
To the Funeral C
completely filled filled 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 26 APRIL RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenie Shieh 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			partment of Health and M		1000
		Registrar C6	ertificate of Death	Reg. No. 201	2 13320
Physic Med	ian/	1. Decedent's Name (First, Middle, Last) Gene Edward Will:		2. Date of Death April 15, Day 2012	3. Time of Death 6:15 PM
Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
<u> </u>		APEX Health of Silver Spring	Silver Spring	Montgome	J
Funera Directo		5. Social Security Number 577-34-8205 6. Sex 1 ★ M 2 □ F 84 Yrs.	If Under 1 Year I If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 12, 1928 Vir	place (State or Foreign ntry) Sinia
d tow		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or L	continu		40.1 (20.1)
arylar a-f sh fied a	Sch	MD Montgomery Silver S			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
he Ma or 28	Dir.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	
with t 23a	Funeral Director	2700 Barker Street	20910	USA	nay.
eath tems	Ē	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - Ameri	can Indian,
ffer d ", or i	ģ	1 ⊠ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Black, White, Specify: Whi	
ours a	ted	3 Widowed 4 Divorced Year or Dates.		Specify: WILL	LE
72 ho	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired	ing 16b. Kind of Business Ir	idustry
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		Elementary/Seconday (0-12) College (1-4 or 5+) Load Truc	e kind of work dorine during most of worki DO NOT use retired) led Delivery Eks	Wonder Br	ead, Inc.
ING 21213-UU36 Filed within 72 hours after death with the Maryland thal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)	
Yia	욘	Luther Clay Will	Amelia A	Agnes Alther	
Maryland 21213-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam			ling Address (Street and Number or Rura)4 Penny Avenue, C1	al Route Number, City or Town, State, Zip	Code)
re, l and f Heal item 2		20a. Method of Disposition 20b. Place of Disp	position (Name of	Date 20c. Location - City or T	own. State
Page Page Int. If		respondi z Sporchation o Strenografion State	ematory or other place) ckson Cemetery 4-19		
bartimore, Marylanc permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve	12		22 . Name and Address of Facility $\stackrel{\circ}{ m D}\epsilon$	llinger Funeral Ho	me
n %QE#6	51	Demis Mit		, Mount Jackson, V	A 22842
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart fallure. List only one cause on each line.	ter the mode of dying, such as cardiac o		Approximate Interval Between
Physician ₄ Medica	_	resulting in death)	Cardiovascular Dise	ease U	Onset and Death NKNOWN
Examine		Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
and transit	xam	Cause (Disease or iinjury that initiated events c.			
ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):			
icate by physics the b	ledic	d			
certifica certifica anding ph use as th	N/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□ Fatania ausanana	23d. Date of deliv	ery
death of atterned after u	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month	Day Year
at the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacco use contribute to t	ha severa of death?
res this signed at be d	d b	Diabetes Mellitus, Hypertension,	andonying dadde givernin arci.	1 Yes 2 No 3 Pro	
requi been shoulk	lete		- d -		psy findings available
The law requires ate has been signage 2 should b	Completed	Peripheral Vascular Disease, Dement	ila	autopsy prior to co performed? death?	mpletion of cause of
an: The ratifical ratios, pa	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check	1 Yes 2 No 1 Yes	2 ⊔ No
VILCI hysician nis certifi	일	Hospital: 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4X Nursing Hor	me 5 Residence 6 Other (Specify	()
ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	work?	28d. Describe how injury occurred	
or Attendir frer death. irector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	00(1)	
I or Attend after death Director; A		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rura City or Town, State)	Houte Number,
Living of view by the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or inve			
the H thin 24 the Fi mplete	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the cause(s) and manner as st	ated.
vit O COI		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	
2		30. Name and address of person who completed cause of death (Item 23a) (Type,	D43121	April 19, 20	J12
4		Nurul Chowdhury, M. D. 605 Main St	reet, Laurel, MD	20707	
	ate	31. Date filed (Month, Day, Year) APR 2 7 2012 Leven D. January			
Regist	rar	AFTI & 1 2012 Kleine B. Ga	RE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ne 2012 1332
			Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Death	Reg. 2. Date of Death	
	Physicia		Sidney David Weinberg			Day Year 12 2012 8:00 A M
my	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
1			3403 Calvend Lane	Kensington		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	Birthplace (State or Foreign
5_	Director		011-24-6638 1X□ M 2 □ F 93 Yrs.	Months Days Hours Min.	(Month, Day, Yea	
	how at	=	Usual Residence of Decedent 93 10a. State 10b. County 10c. City, Town or L	ocation	2-12-1919	9 Massachusetts 10d. Inside City Limits
	anylar a-fs	S				1 Type Yes 2 No
	he M or 28	<u> </u>	MD Montgomery Chevy Cha	10f. Zip Code	10a	Citizen of What Country?
	with t	Funeral Director	8100 Connecticut Avenue #901	20815	l log.	United States
	eath tems er mu	جّا	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
9	ter d , or it	β	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No 1943 1946 1946	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
21215-0036	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	3X Widowed 4 □ Divorced If Yes, Give Year or Dates. 1946	1 ☐ Yes 2 🗓 No Specify:		Specify: White
5	72 ho "nai edica	lg	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work	ing 16b	o. Kind of Business/Industry
12	iled within 72 Il Hygiene. other than '	Son .	College (1-4 or 5+)	DO NOT use retired)	,	ord Deed Inc.
d 2	filed w al Hygi d other	Be (17. Father's Name (First, Middle, Last)	orney	e (First, Middle, Maid	Rail Road Law
Maryland	should be file h and Mental H 7 is marked o traumatic eve	2	Benjamin Weinberg	Rose Ku		en Sumamej
ary	nd M s mai		10. 16 10. 11. 65 27. 11	ing Address (Street and Number or Rura		vor Town State Zin Code)
Σ	d 2 shath a atth a 27 is			Aldershot Lane, Mai	-	
Je,	of Health and Ments of Health and Ments of Item 27 is marked rother traumatic e		20a. Method of Disposition 20b. Place of Disp	osition (Name of		Location - City or Town, State
mc	Page nent c			emorial Park 4-15	-2012 Sh	naron, Massachusetts
Baltimore,	permit, Page 1: Department of I Important: If It any injury or or		21. Signature of Funeral Service Live See Edward Sage 2	2. Name and Address of Facility		-Goldberg
<u> </u>	90 E # 9	-))	M00910 1	.170 Rockville Pike		le, Maryland 20852
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between
~	Physician/	i n	Immediate Cause (Final disease or condition Metastatic Lung (Cancer		Onset and Death 1 Month
1	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		er	Sequentially list conditions, b.			
	ed nsit	min	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	ate be executed hysician and the burial-transit	dical Examiner	that initiated events c. Due to (or as a consequence of):			
09	s be e	ical	L _d			
376	ficate g phy as the	Jed				
(687	eath certifica attending pl	Z	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐	☐ Ectopic pregnancy		23d. Date of delivery
Box	death ne ath ed for	sici	1 Ves 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
P.O.	es that the dea igned by the a be detached t	Physician/Me	9 - Olikilowii			
σ.	res that signed d be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
rds	require been sig should I	ted			1 L Yes	2 □ No 3 □ Probably 4X Unknown
Records,	e law n has b ge 2 st	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	Physician: The lav r this certificate has eral director, page 2				performed 1 Yes 2	2 death? No 1 ☐ Yes 2 ☐ No
ţ	ician certif	m	25. Was case referred to medical examiner? 1 Ves 2X No	26. Place of Death (Check		Second Residence
<u>_</u>	Phys this	유	1 Yes 2X No			6A Other (Specify)
n o	ding th. After	Certificate:	1 XNatural 5 Pending (Month, Day, Year) injury	t 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how inj	jury occurred
sio	Atten r deal ctor:	Ě	3 Suicide 6 Could not be		28f Location (Street	and Number or Rural Route Number.
Division of Vital	al or safter		4 ☐ Homicide determined building, etc. (Specify)	[City or Town, Sta	
_	ospit hour unera	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	nd due to the cause(s)) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge	death occurred at the time, date and pla	trie time, date and pla ce, and due to the cau	ace, and due to the cause(s) and manner stated. use(s) and manner as stated.
	B 의 禁 의		29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
			for the fam	D33554	4-	12-12
	101	4	30. Name and address of person who completed cause of death (tern 23a) (Type, I			0.0015
	Stat		31 Date filed (Month Assay Year) 1 22 Registraria Signatura	nue, Ste 117, Wash	nington, D	00 20015
	Registra		31. Of te filed (Month, PR 727) 7 2012 32 Registrar's Signature	well		
			1100			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Louise В. Werner April 2012 4:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maples of Towson Towson Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Months 409-48-4872 Davs Hours Director 1 M 2 X F 85 Yrs 1927 Feb. 6. Ohio r 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD. Baltimore Towson 1 Yes 2X No 10e. Street and Number ō 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 1201 Providence Rd. 21286 USA ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Force 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Communications t. Page 1 and 2 should be filed with thent of Health and Mental Hygier rtant; If Item 27 is marked other t njury or other traumatic event, th 4 Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vernon Barrett Isabella VanHook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Carol Werner/ Stepdaughter in Law 3111 Moravia Rd. Baltimore, MD. 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4-28-12 Dulanev Vallev Mem. Timonium, MD. 4 Donation 5 X Other (Seast ombment 21. Signature of Funeral Service Likenses 22. Name and Address Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cau Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 3 months Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the t ending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Ho 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 2 Divo 1 T Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After the din by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours a To the Funeral L Medical

Registrar DHMH 17 Rev 06-2011

State

20a Certifier

(Check

31. Date filed (Month, Day, Year)

E

e and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

64/26/2012

RO79544

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BeTT 730 M WALLACE Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death Examiner 4c. County of Death naryland timore 7. Age (h yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) **Director** 1 □ M 2 🗓 F 217-44-2664 66 JUNE 2 1945 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD PRINCE GEORGE'S BLADENSBURG 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be with Funeral 20710 USA 5800 ANNAPOLIS ROAD #10 items ? permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other transmatic event, the Medical Examiner m 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc þ 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH SECURITY GUARD PRIVATE Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PRESTON WALLACE LOUISE GROSS Baltimore, Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $13112\ 5TH\ STREET\ BOWIE,\ MARYLAND\ 20720$ SELENA L. ROBERTS-BELTON/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 5/2/2012 RIVERDALE, MARYLAND J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service License 22. Name and Address of Facility Waphne N. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death PSis Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner (ancer or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? after death.

Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Certificate: To 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature apdittle of 29d. Date signed (Month, Day, Year) APRIL 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year

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MI

Bretimore MD

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 13324 amenetale of Maryland / Department/of Health and Mental Hygiene

	1- For State Registrar		Certifica	te of Death			Reg. No.		
Physician Medical Examine	Decedent's Name (First, Middle,Last) Michael Williams					2. Date of Dea Month April 25, 2	Day Year 2 012	3. Time of Death 2317 hrs	
	Facility Name (if not institution, give street and number) University Hospital			4b. City, Tow Baltimor	re, or Location of Death 4c. County of Death N/A				
Funeral Director	5. Social Security Number 218-82-47	73 M 2 F	e (In yrs. last birth 45		Year If Under Days Hours		rth(MM/DD/YYYY) 9. B / 6 6 Fore C		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmatie event, the Medical Examiner must be notified at once. To Be Completed by Firneral Director	Usual Residence of Dece 10a. State 10b. (MD I		ty, Town or Location ltimore			10d. Inside City Li 1 🛣 Yes 2			
			10f. Zip Code 2 1 2 1 7			10g. Citizen of What Country? USA			
	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced or Dates:			If Yes, specify Co	uban, Mexican No specify:	gin? (Specify Yes or No Puerto Rican, etc.)	White, etc. African specifyAmer.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)						/Industry		
	Aysel Dru	mmond			Anni	s Name (First, Middle, .e Drummo)	nd		
		elatiospia (Type, Print) mm#nd/Mother					nber, City or Town, State, Zip Code)		
	1 Burial 2 Cremation 3 Removal from State Bayvie			Disposition (Name or or other place) ew Crem		Date 5/5/12	20c. Location - City or Town, State Balt., MD		
	5126 Belair Rd, Balt., MD 21206-5105								
Physician /Medicar Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death								
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
uted d ansit Fxaminer	(Disease or injury trian initiated events resulting in death) Last Due to (or as a consequence of):								
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the death certificat by the attending phoched for use as the		ant in the 1 Live birth 4 Pregnant at	Pregnant at time of death 5 Other (Specify)				23d. Date of delivery Month Day Year		
P.O. BOS es that the death igned by the att	1 Yes 2 No 3 Probably 4 Unkr								
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tal Recletan: The certificate rector, page									
F Vital Physician r this cert al directo	1 Ves 2 No Impatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other:							r:	
·# 불유용도		Pending 28a. Date of Injur Apr 25, 2012	ear)		Injury at Work	Subject sho	how injury occurred t		
Division o the Hospital or Attending hin 24 hours after death. the Funeral Director: Aft apletely filled in by the fune iteal Centification:	3 Suicide 6 4 Homicide	_ Could not be	not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			or Town, S	28f. Location (Street and Number or Rural Route Number, City or Town, State) 2500 Harlem Avenue, Baltimore, MD		
Divis To the Rospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
2							29d. Date signed (Mo	onth, Day, Year)	
	30. Name Ind ad ress of	30. Name and ad ress of person who completed cause of de th (frem 23a)							
21	Russell Alexand	/		900 W. Baltimo	ore Street,	Baltimore, MD 21	223		
State Registra		2012 32. Registrar	's Signature	Kel					

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State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryland A		tificate o			iemai rry	Rea. No.	201	2 133	25
ľ	Physicia	n/	Decedent's Name (First, Middle, Last)					Date of Dea Month	ath Dav		3. Time of De	eath
	Medic Examin	al	Cristy Lyn Wade 4a. Facility Name (if not institution, give street and number)		4b. City. Tow	n, or Loca	ation of Death	APRIL	1	County of Dea	2 10:15	M
red.	LAGIIIII	.	Baltimore Washington Med. Ctr.		GLE	EN	BUR	NIE	A		ARUND	EL
4	Funeral Director	112	5. Social Security Number 6. Sex 7. Age (In yrs. last I		If Under 1 Ye Months Da		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Day	h /, Year)		thplace (State or Fo puntry)	oreign
		ű.	Usual Residence of Decedent 48					10/26	/196	3 Ma	aryland	
	rryland I-f sho ied at	Director	10a. State 10b. County 10c. City, To		ation						10d. Inside City L	
	he Ma or 28a e notif	Dire	MD Anne Arundel Jess 10e. Street and Number	up	10f. Zip Coo	le			10g. Citi;	zen of What C		110
	with t	Funeral	7810 Clark Road, Lot D84		207	94				S.A.		
	death r item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of Yes, specify C	of Hispan Juban, M	nic Origin? (Spe exican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			-
036	led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.	1	☐ Yes 2 🕱	No Sp	pecify:		5	216"	hite	:
21215-0036	2 hour "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decede	ent's Usual Oc	cupation	n g most of worki	rking 16b.		b. Kind of Business/Industry		
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ylar	D = 4	은	Warren Earl Wade				June	Ruth	Warf	ield		
Maryland	2 should be the and Mer 27 is market traumatic		r T		-			l Route Number				
	1 and 2 Healt item 2 other		20a. Method of Disposition 20b. Place	e of Dispos	sition (Name of			oad, Ode		cation - City or		
mo	42 O 4- L		I Durial 2 Colemation 3 C Removal non-State		atory or other. fts Regi:		04/2	7/2012		_	aryland	
Baltimore,	permit. Page Department Important: I any injury o		21. Signature / Funeral Servic Licensee	22.	. Name and Ad	dress of	Facility Z	Anatomy	Gift	s Regi	stry	6
•			23a. Part 1. Enter the disease or complications that caused the death. D					-		anover,	MD 21076 Approximate	
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J	Medical Examiner		resulting in death) Due to (or as a consequence A C 13 T F	ce of):	SPIR	AT	ORY	EAII	I(R	F	5 DA	75
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ž X	th certi ttendin or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1						2	3d. Date of de	elivery Day Year	,
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ř	sician: The law a certificate has t lirector, page 2 s		25. Was case referred to medical		26	Place o	of Death (Check	1 Tyes			s 2 No	
VIT3	lysicia is cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	Outpatient		Other:		me 5 🗆 Resid	ence 6	Other (Spec	cify)	
Division of	To the Hospital or Attending Physician: within 24 hours after death and the Funeral Director. After this certific completely filled in by the funeral director.		1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	b. Time of injury	V	njury at vork?	2 🗆 No	28d. Describe h	ow injury	occurred		
ISIO	Atten er deat ector: by the	Certificate:	2	, farm, stre				28f. Location (S City or Tow		Number or Ru	ral Route Number,	
2	pital or ours aft eral Dir filled in		2ga. Certifier 1 🔀 Certifying Physician: To the best of my knowledge	e dooth o	courred at the	time dat	te and place a			d manner as s	tated	
	ne Hos in 24 h ne Fun pletely	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the basis of examination an	d/or investi	igation, in my o	pinion, de	eath occurred at	the time, date a	nd place,	and due to the	cause(s) and manne	er stated.
	To t To t		29b. Signature and title of certifier Same Jain MD			ense num				signed (Mont		2
			30. Name and address of person who completed cause of death (Item 23.	a) (Type Pr		/ - (0107		/(//	16	24, 201	_
			SAMIR JAIN 30	1 H	05817	AL	DRIV	E. GLER	Y BU	RNIE,	MD 210	61
f	Stat		31. Date filed (Month, Day, Year) 32. Roman's Signature	1 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April 24 2012 Elizabeth McKenrick Winstead 6:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 01/08/1939 Maryland Days Min. 1 🗆 M 2 🗀 F Director 212-38-4362 73 Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location with the Maryland Director must be notified Yes 2 No MD Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 816 Drohmer Place 21210 **USA** permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 'natural", or Completed by 1 Never Married 2X Married Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event; the Meaones. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles McKenrick Elizabeth Howson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Winstead III / Husband 816 Drohmer Place, Baltimore, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/26/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshat Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Curcinimi 10 disease or condition resulting in death) any withi Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events burial-tra Hospital or Attending Physician; The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Ise 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Dav Year Other (specify) Pregnant at time of death 9 Unknown Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury within 24 hours area Co. To the Funeral Director. After Consider the funeral Director. work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 3 only one 29b. Signature and title of certif

Q,

State Registrar 6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NES

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2, MMERMAN 4c. County of Death 4a. Facility Name (if not in titution, give street and number 4b. City, Town, or Location of Death Howard 3781 Plum Meadow Drive Ellicott City g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Month, Day, Year) 09/01/1925 Country) 1 🗆 M 🛂 🗆 F 86 346-24-2743 10d. Inside City Limits 10b. County 10c. City, Town or Location X□ Yes 2□ No Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21042 3781 Plum Meadow Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 Yes No 1 Never Married 2 Married 1 Yes X No Specify: Specify. Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Juneau Clarence Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3781 Plum Meadow Drive, Ellicott City, MD 21042 Beth Ann Howard / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial X☐ Cremation 3 ☐ Removal from State Beltsville, MD 4/27/2012 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 1) orale Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

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Department of H
Important: If ite
any injury or ot

Physician/

Medical

10a. State

Funeral Director

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Examiner

Funeral

Director

or 28a-f show

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shov jury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as use

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner Completed by Be မ

Certificate: Medical

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 24a. Was an autopsy 2 **N**O 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Homicide

28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

(Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and ti

24b. Were autopsy findings available prior to completion of cause of

death? 1 Yes

State Registrar 31. Date filed (Month, Day, APR 2 7 2012

29a. Certifier

Please Type of Long in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 8.9.10d per fh. 9927.05/03/2012dhb

State of Maryland / Department of Health and Mental Hygiene

Amend Itesm 21,22 per fh. 9925.03/09/2012dhb

Reg. No. 20 | 2 For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Vear FILA 0029 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Baltimore Baltimore entes Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. Hours Director 1 M 2 X Yrs. 2 30 01/23/2012 MD 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Completed by Funeral Director 1 🗆 Yes 2 🗶 No Anne 10e. Street and Number or items 23a or 10f. Zip Code 10g. Citizen of What Country? SA CEDAR 85 21146 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedary
Armed Forces?
1 Yes 2 No 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: ASIAN "natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha NFANT INFANT Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sag 16 Shat 19a. Informan's Name/Relationship (Type, Khan traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. SEVERN Aisha MO CEDAR DR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) STAFFORD AMAA 23 13 Signature of Funeral Service Licensee Harry Close 22. Name and Address of Facility THAM per dyr VA 20151 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2.5 hours Preterm Immediate Cause (Final 216/7 Physician/ at disease or condition resulting in death) Hivery neeks Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnarl ransit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🗖 No Other: 1 Nation 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1386943918 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Desai M.D Greene St S 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 9 2012 MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1-00 Mollie Leonie Bertling 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE BHINT HG N'ES HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XXF Months Hours Country) Georgia Director 579-22-5203 93 Usual Residence of Decedent Show i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No MD Elkridge Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 6274 Montgomery Road 21075 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3xxWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Anderson Crowe Mollie Leonie Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald G. Bertling - son 318 Monterey Avenue, Liberty, Missouri 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem Park! 04-27-2012 Elkridge, Maryland o Fune al S, rvi L e 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signat MMP Inc. 7250 Wash. Blvd, Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final POVEUMONI Onset and Death Physician. DIMMUNIT ACQUIRED disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RENAL FAILURE, RHABDO MYOLYSIS 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available ACIDOSIS URINARY TRACT IN FECTION 24a. Was an autoosy prior to completion of cause of death? has ALZHEIMER'S DEMENTIA TUDE I DIABETES this certificate 25. Was case referred to medical 26. Place of Death (Check only one) ERTHING examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director; completed filled in by the 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0018362 Komal 4-24-20/2 Name and address of person who completed cause of death (Item 23a) (Type, Print) KOMAL K. DANG MD. 3455. W Wilkens Ave, Ste LIO; Baltimore, Md21229 101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 3 0 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13330 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Mildred Bel1 9:18a Apri1 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4709 Linthicum Road Davton Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Months Director 267-36-4328 93 1 □ M 2 □XF June 10 1918 MD Usual Residence of Dec 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director MD Howard Dayton 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4709 Linthicum Road 21036 USA or items death 2. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 Married Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 is marked other than "any injury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) salesperson retail sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elmer VanHorn Rose Kirchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gary Bell (son) 4709 Linthicum Rd., Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Note

Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clarksville, MD Linthicum Chapel Cem! 4-26-12 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Dauge Haight Herbert Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) probable mang , Medical Examiner Esquartiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed AMULT sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for Dav Pregnant at time of death ed by the a detached f g Unknown Unknown Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate has autopsy 2 🗷 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 KNo 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 A Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending ector A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Direc City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hountly to the second to the secon 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) APRIL 24, 2012

Registrar

State

CAMUSVILLE MA 21029

The ones

no completed cause of death (Item 23a) (Type, Print)

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, JACKSON.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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3036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes 2 XXNo	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	etc.							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 14 Year 2012 Month **Physician** GIEORGE 11.25PM BARBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/10/43 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 212-42-1624 68 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evancines must be a puffied at one. Maryland Baltimore 1√Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 3709 Elmley Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Be Completed by Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Barber Mary Barber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3709 Elmley Avenue Baltimore, Md. 21213 Gloria J.Barber 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 05/01at/12 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, Md. Greenmount Cemeterv 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Md. 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER RECTUM WITHMETHSTASIS Physician disease or condition resulting in death) /Medical Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and HYPERTENSION After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 □ No □Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 NO 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 10 Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0072328 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBORHOSFITAL BALTIMORE, MD. RAGHURAM CHAVA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year					
. 40	Medic	cal	Anne Elizabeth Brown 4a. Facility Name (If not institution, give street and number)	Ab. City Tayre and agation of Dogth	April	27, 2012 8:15 P. M					
	Examir	ier	Gilchrist Hospice	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore					
Ī	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	9. Birthplace (State or Foreign					
	Director		214-44-9396 Usual Residence of Decedent 1 □ M 2 🔀 F 67 Yrs.			6,1945 Maryland					
	/land f shov	tor	10a. State 10b. County 10c. City, Town or L		'	10d. Inside City Limits					
:	e Mary r 28a- notifie	Direc	Maryland Baltimo			1X Yes 2 □ No					
7	with th 23a o Ist be	Funeral Director	5025 Orville Avenue	10f. Zip Code 21205	10	g. Citizen of What Country? U.S.A.					
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36	after al", or xamir	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No If Yes, Give	1 ☐ Yes 2 No Specify:	Thour, Co.,	Black, White, etc. Specify: White					
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/lan	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	입	Connor Corkran		ne Liedl:						
Maryland	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The and Mental Hygiene is a strong that the strong that the strong other traumatic event, the Medical Examiner must be notified at	8		ling Address (Street and Number or Rura							
φ.	and 2 s Health tem 27 other tra		Anne Catherine Brown: Daughter 50 20a. Method of Disposition 20b. Place of Disp			e, Mary Land 21205 Oc. Location - City or Town, State					
Baltimore,	permit. Page 1 Department of Important; If it any injury or o once.		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State cemetery, cri	ematory or other place) Cremation, Inc. 4-30		Manover, Maryland					
3alti	ermit. epartin nporta ny inju nce.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ma	rzullo Fu	meral Chapel,P.A.					
	₫ □ = 6 0			5009 Harford Road,							
23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition of the cause (Final disease or condition of the cause of the cause of the cause (Final disease or condition of the cause (Final disease or condition of the cause of the cause (Final disease or condition).											
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الم الم	usit eu	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury								
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Records,	ate has I	Completed			autopsy performe 1 \(\superstack \text{Yes}\) 2	prior to completion of cause of					
Vital	certificate has lirector, page 2	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check		2 100					
OT VI	r this c	요 ::	1	4	me 5 Residence	ce 6 Other (Specify) WO SUU					
ono	ath. ir. Afte	icat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	Edd. Describe now	injury occurred					
DIVISION Falor Attendir	fter de hirecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)					
J Figure	within 24 hours after death. To the Funeral Director: After this certification of the funeral director, completely filled in by the funeral director.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, ar	nd due to the cause	e(s) and manner as stated					
he Ho	in 24 the Fur	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at	the time, date and p	place, and due to the cause(s) and manner stated.					
Ī	To t		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)					
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	9 30 90	> #	the 15 2012					
	5		AANON] CHANES MO (201 N. Char	les ST	- Im con mo					
	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2012 0639 AM Roxanne Bonnette Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton, Prince Georges Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Hours **Director** 240-08-3480 1 \square M 2 \square F 55 Sept.16,1956 New York 28a-f show 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD P.G. Upper Marlboro 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9103 Jousting Ln 20772 USA should be filed within 72 hours after death vand Mental Hygiene. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Funeral Home Proprietor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leroy Jones Jeanetta Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 9103 Jousting Ln. Upper Marlboro Md 20772 <u>James Bonnette</u> (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) May5,2012 Resurrection Clinton 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 2504 28th St. 20018 Bonnette&Assoc.FuneralHm.Washington,D Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mycardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer 1 Yes 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of death? performed' 2 4 No Yes 2 4 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 III No Other: 잍 1 \square Yes 1 Inpatient 2 IDER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? __1 ☐ Yes _2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director; 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 41124112 1 mo 12666131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Davis 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Bankard 2012 Brown 6:45 PM Medical Apri] 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lorien Mt. Airy Mt. Airy 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Davs Hours Director 217-14-3687 1 🔀 M 2 🗆 F 91 1921 Feb. 27, Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Union Bridge Maryland Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 924 Winters Church Rd. 21791 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces 2 1 Never Married 2 Married 72 hours after ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", If Yes, Give Completed 3 X Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 8 contract construction carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William E. Brown Ethel Bankard and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Donna K. Rucker/ daughter 15111 Parrish Rd. Upperco, MD 21155 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/30/2012 Westminster, MD Meadow Branch Cem. Simalification uneral Service L 22. Name and Address of Facility Hartzler Funeral Home, P.A. Jarine (1 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death prostate cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner bladder cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g 🗌 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has le 2 autopsy page 2 performed? death? certificate 2 No 2 🔀 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral di 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 XNatural work 1 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Funeral [Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar

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Asha Vali

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

only one)

dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

12640 Clarksville Pike

D0052861

29d. Date signed (Month. Day. Year)

4/27/2012

Clarksville, MD 21029

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth JONES Cutlip Physician/ 2017ea 140 PM CUTUP NPE CLAMA ELIZASETH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard HOWARD WOUNTY SONEAR HOSPITA Corumsia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) . Social Security Number **Funeral** Days Director 215-18-0196 90 Jan.9, 1922 Maryland show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County Director 1 X Yes 2 No Prince George's Hyattsville MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with 7010 24th Ave. 20783 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2X No Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event; the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 7 f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 12 Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Edward Ross Jones Marie Springirth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Weber / daughter 14501 Galway Gardens Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State Hinal Journey Crematory 4/26/12 Woodbine, MD 4 Donation 5 Other (Specify) permit. 21. Signature of uneral Service Ligensee Going Home tremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M el M01651 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ METATATIC LUNG man THS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the at d be detached for 1 Yes 2 S Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPILATIONY FARWALE 1 1 S 2 No 3 Probably 4 Unknown Mylmonnas misense 24b. Were autopsy findings available prior to completion of cause of 025TNV5T-103 24a. Was an certificate has autopsy death? performed' Ronn MUTO 1 Yes 2 No 1 Yes ours after death.

eral Director: After this certifica
filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Impatient 2 I ER/Outpatient 3 I DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Matural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 036974 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) on walnuth. O . DITO CUARTOR DR. 10310 Columbia no 21524 DAVO 32. Registrar's Sign State

Registrar

•		• •	Department of Legith and Montal Live	•								
		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 2 3 3 3										
24	٠,	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death									
Physici Med	cal	Vernon Cook	AR MONTH	Da24 Yelr 2 13:05								
Exami	ner	4a. Facility Renge (Amb Mailitylib Daniel Street Jack gustig); 7a	4b. City, Town, or cocation of Death ROUGH TOWN MD	Baltimore Count								
Funera Director		5. Social Security Number 219-03-6354 6. Sex 7. Age (In yrs. last bin 1 □ M 2 ☒ F	thday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Yrs.									
od te	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits								
Maryland 28a-f show otified at	recto		imore	1 🔀 Yes 2 □ No								
th the Man	Funeral Director	10e. Street and Number 3917 Bareva Road	10f. Zip Code 21215	10g. Citizen of What Country?								
ath wi	nuel	11. Marital Status 12. Was Decedent Ever in U.S.		14. Race - American Indian,								
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ò	1 Never Married 2 Married 1 X Yes 2 No 1 Yes, Give	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	Black, White, etc. Specify:Black								
hours	lete	15. Decedent's Education 16a	a. Decedent's Usual Occupation	16b. Kind of Business/Industry								
1215 nin 721 ne. than "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	B&O Railroad								
d 21 ed with Hygier other i	Be C	12th grade 17. Father's Name (First, Middle, Last)	Maintenace 18. Mother's Name (First, Middle, N	Maiden Surnamel								
/lan	2	James Morrison Cook	Viola Blake									
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant; If item 27 is marked other than "natural", on my injury or other traumatic event, the Medical Exampne.			b. Mailing Address (Street and Number or Rural Route Number, 922 Rolling Rd. Pikesvill									
re, I		20a. Method of Disposition 20b. Place of	151 111 111 1	20c. Location - City or Town, State								
Page Tent of ant; If oury or		1X Burial 2 □ Cremation 3 □ Removal from State Garri	or Disposition (Name of erry, crematory or other place) son Forest 05/03/12	Owings Mills,Md.								
Balt permit. Depart Import any inji		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Chatman-F 5240 Reisterstown Rd.Ba									
		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	2 2 1	Interval Between								
Physician Medica	1	disease or condition resulting in death) a. Due to (or y consequence	tage Kenal Failui	_								
Examine		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of:									
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
be executed sician and burial-transit	l <u>a</u>	resulting in death) Last Due to (or as a consequence	of):									
	Aedio	d										
Box 68760 death certificate be the attending physined for use as the b	ian/N	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat		23d. Date of delivery Month Day Year								
o.O. Bc hat the dea ed by the a detached f	Physician/Medi	1 Yes 2 No 9 Unknown	5 Other (specify)									
Division of Vital Records, P.O. Box 6876(to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician peterly filled in by the funeral director, page 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting		bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown								
SCOFC law req has bee	Completed		24a. Was a autope perfor	prior to completion of cause of death?								
III: The lifticate or, pag	ပိ	25. Was case referred to medical		2 No 1 Yes 2 No								
Vita ysicia ysicia js cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Othor	ence 6 Other (Specify)								
on of ording Pharmal After the funeral	cate:		Time of injury at work? M 28c. Injury at work? 1 □ Yes 2 □ No	ow injury occurred								
ivisic or Atter after dea Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office 28f. Location (St City or Town	reet and Number or Rural Route Number, n, State)								
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, and due to the cat or investigation, in my opinion, death occurred at the time, date an owledge, death occurred at the time, date and place, and due to the	id place, and due to the cause(s) and manner stated.								
To the within To the compl	2	205. Signature and title of certifier	29c. License number	29d. Date signed (Month) Day, Year)								
- HV		30. Mame and address of person who completed cause of death (Item 23a)	D46374 Type, Print) Old Covit Rd. Ra	101/2 100								
St.	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	401 Old Covit Rd. Ka	nacilistown MD								
Regist		APR 3 0 2012 Same B.	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Carroll Lillian Wilhemina 2012 7:22 P April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Village Care Center Baltimore Parkville 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 216–12–2180 7. Age (In vrs. last birthday) **Funeral** Hours Year) Maryland **Director** 1 🗆 M 2 🗓 F Feb. 11,1915 97 show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f Glen Rock 1 Ves 2 X No PA York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or ms 23a or must be r 17327 3075 Rexwood Drive United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Specify: 3 X Widowed 4 ☐ Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker 7 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever မ Ruby Norris Cadle Page 1 and 2 should be ment of Health and Ment Walter Remington Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Mr. Dennis E. Carroll (Son) 3075 Rexwood Drive Glen Rock, PA 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Holly Hill Mem. Gdns. 4/30/2012 Middle River, MD 4 Donation 5 Other (Specify) uture of Funeral Service Lice Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Pact 1. Siter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Privalciun/ Vascular Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year ☐ Pregnant a
☐ Unknown Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lerebrova Scular Disease 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 4/26/2012 R171944 CRNP, MIN ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Hatrison

30

32. Registrar's Signature

8800 Walther Blvd, Parkville MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u> April</u> 2012 5:19 P Crushona Emma Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 57B Hoff Road Union Bridge If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 218-30-8933 **Director** 1 M 2 X F 77 Jun. 24, 1934 Maryland Usual Residence of Deced 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 57B Hoff Rd. 21791 U.S.A. items death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, ed other than "natural", or iter event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed with. Hygiene. Ser than "r (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other ti <u>custodial</u> staff public schools 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Albaugh Mary Louise Steel other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau e 1 and 2 s of Health Thomas C. Crushong/ husband 57B Hoff Rd. Union Bridge, MD 21791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State All County Cremation 4/24/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Hartzler Funeral Home, P.A. Jan de E. Broadway Union Bridge, MD 21791 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Accident Onset and Death Immediate Cause (Final Vascular Physician/ evenio west disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death be detached 1 Yes 2 L signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 ☐ Yes 2 ☐ NO funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🔲 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

52035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHACKO 295 Stoner

State Registrar 29a. Certifier

only one) 29b. Signature and title of certifier

elu

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 3 0 201

1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Mo

2012

21157

April

Wechnerba

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Suzanna Herrera 1. For State Certificate of Death Reg No Registrar 2. Date of Death Physician/ Decedent's Name (First, Middle, Last) Month Day April 20, 2012 1640 hrs **Medical Examiner** SUSANA HERRERA CARRILLO 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director October21. 1990 Country) Guatemal NONE 1 M 2X F 21 Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits 10a State Yes 2 No PRINCE GEORGE HYATTSVILLE 28a-f shov MD items 23a or 28a-f shoust he notified at once. 10f. Zip Code 10g. Citizen of What Country' 10e Street and Number Ö 8207 14th Ave # 102 20783 Guatemala Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes If Yes, Give Year 1 x Yes 2 No specify: Guatemalan Specify: Latino 3 Widowed Divorced ģ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed it. Pages 1 and 2 should be filed within 72 hou timent of Health and Mental Hygiene. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other thao "traumatic eveot, the Medical Laundry Services, Co Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDILIA CARRILLO ANSELMO HERRERA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8707 Barron ST, #2 Tacoma, Park, MD 20912 RODOLFO Esquivel(brother in Law) 20c. Location - City or Town, State Naranjo Frontera La 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Department of He Important: If ite injury or other t crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05/4/12 Barrio El Cementerio ∟ibertad PetenGuatemal Donation 5 Other Specify Supremental Service License 22 Name and Address of Facility Santa Cruz Funeral Services, 00 Kennedy ST, NW.:Washington, DC 20011 Approximate Interval disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death a Complications of Blunt Force Head Trauma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Caust (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED # 1 as noted, 23a, 27, 28a-f, per me, g930 8-10-12 sm X UNPENDED signed by the attending physician be detached for use as the burial law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of Other (Specify) 5 Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Yes 2 ✔ No 3 Probably 4 Unknown Completed this certificate has been s I director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No ~ Yes To the Hospital or Atteoding Physician: within 24 hours after death.

To the Fuoeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26 Place of Death (Check only one Division of Vital Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: jumped from moving subject vehicle Natural Yes 2 X No Pending fd 4-9-12 fd 2325 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be or Town, State) 18120 New Hampshire ye. Cloverly, MD. (Specify Fd: Roadway Ave. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. April 22, 2012 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MI. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year, State Registrar

Registrar's Signature

2-03077	Please Type or Print in Black Indelible Ink. Ensure All Copies Are 1	.egible.		
erry Edward Doane	State of Maryland / Department of Health and Mental Hygiene	Th.	2012	13
1- For State	Certificate of Death	Don No	2012	1 0

rry Edward D	oane		artment of rtificate of		ental Hyg	iene Reg. N	20	12 13343
Physici edical Exam		1. Decedent's Name (First, Middle,Last) Jerry Edward Doane				Date of Oeath Month Da April 20, 2012	v Year	3. Time of Death 1305 hrs
		4a. Facility Name (if not institution, give street and number) 6260 Washington Boulevard	4	b. City, Town, or Locati Elkridge		(prii 20, 2012	4c. County of De Howard	eath .
Funeral Director		5. Social Security Number 229-72-2493 6. Sex 1 7. Age (In yrs. la	last birthday) Yrs.		ours Min	B. Date of Birth (M	ÎFo	Birthplace (State or reign Countying inia
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Virginia 10b. County Virginia Smythe 10c. City, Sate Virginia 10b. County Virginia Smythe 10c. City, Sate 10c. Street and Number 1849 Valley Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) David Henry Doane 19a. Informant's Name/Relationship (Type, Print) Brenna S. Doane— Daughter	24370 anic Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) specify: Specify: Specify On (Give kind of work done OD NOT use retired)		White, etc. Specify: No. Kind of Busine Fire Proper Surname) City or Town, Sirginia 2	nerican Indian, Black, White ss/Industry Cotection Late, Zip Code)		
Baltimore, permit. Pages 1 an. Department of Heal Important: If iten		1 X Burial 2 Cremation 3 X Removal from State	. Pleasa 22. No. 725	ant <u>Cemeter</u> ame and Address of Fac 50 Washingt	y 04/24 cility Gary on Blvd	1/2012 L. Kau	fman F.F idge, Ma	e Virginia
Box 68760, If the death certificate be executed to the attending physician and the attending physician and the death cransit of the burial - transit	sician/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final discusse or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	of): of): inancy 2 Fet		opic pregnancy		3d, Date of deliv	Between Onset and Death Very Day Year
Vital Records, P.O. sylcian: The law requires that the list certificate has been signed by director, page 2 should be detach	To Be Completed by Physicia	Part II. Other significant conditions contributing to death but not re Lung disease 25. Was case referred to medical examiner?	esulting in the un	26.Place of Dea	ath (Check only	1 Yes 2 24a. Was an autopsy performed 1 Yes 2	No 3 P	Yes 2 No
Division of Y To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical Certification: T	27. Manner of Death 1 V Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medicai Examiner: On the basis of examination are	ge, death occurr	1 Yes 2	No 28 place, and due	or Town, State)	and Number or	
To To with To Com	Med	29b. Signature and title of certifier	400	29c. License numb	per		d. Date signed <i>(I</i>	Month, Day, Year)
5V		30. Name and address of person who completed cause of death (Item Mary G. Ripple MD. Deputy Shief Medical Exam	miner 900	W. Baltimore Stre	et, Baltimo	re, MD 21223	}	
Segrie	tate	31. Date A P P 0 3. Pay 2 32 Registrary Signary	2000					

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	1- For State		nent of Health and Men cate of Death	ntal Hygiene Reg. f	2012	1334		
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	+ Dorsey Jr	<i>.</i>	2. Date of Death Month Da April 24, 201	ay Year 2	3. Time of Death 2242 hrs		
	4a. Facility Name (if not institution, give Sinai Hospital	street and number)	4b. City, Town, or Location Baltimore	of Death	4c. County of Death			
Funeral Director	5. Social Security Number 6. Sex 216-54-3664 1点	7. Age (in yrs. last b	irthday) If Under 1 Year If Under 9 Yrs. Months Days Hours	8. Date of Birth (No. 10 / 0 / 0 / 0 / 0 / 0 / 0 / 0 / 0 / 0	1952 Foreign Cour			
nd show any sce.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location timore			10d. Inside City Limits		
th the Maryland 23a or 28a-f sho aosified at once al Director	10e. Street and Number 4114 Norfolk	Avenue	10f. Zip Code 2/2/16		Citizen of What Countr USA			
s after death witi ral", or items 2 liner must be a	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Yes 2 No To Dates:	13. Was Decedent of Hispanic Original In Test Specify Cuban, Mexican 1 Yes 2 No specify:	n, Puerto Rican, etc.)	14. Race - America White, etc. Specify: R/A	in Indian, Black,		
16 n 72 hours nan "natu ical Exan	15. Decedent's Education (Specify only Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give during most of working life. DO NOT		b. Kind of Business/Ind	dustry / (Joanin)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than Injury or other traumatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) Floyd A. Dovse	y Sr.	Bei	r's Name (First, Middle, Maid	Coates	7 Creaming		
e, MD 21 I and 2 should Health and Mel item 27 is man r traumatic ev	19a. Inf I mant's Name/Relationship (Ty Linux Jume) Do	orsey Wife <	of Disposition (Name of cemetery,	enue Balti	City or Town, State, 2	yland 212		
Baltimore, permit. Pages I a Department of He Important: If ite	1 V Burial 2 Cremation 3 4 Donation 5 Other Specify. 3. Signature of Funeral Service License	Gar	atory or other place) LISON FOVEST 22. Name and Address of Facility	5/3/2012 0	Wings Mil	KMD re NH. AK		
m 립스트로 Physician	28a. Part I. Enter the disease, or complic failure. List only one cause on each	line.	not enter the glode of dying, such as c	ardiac or respiratory arrest,	timore, MI shock, or healt	Approximate I erva Between Onset and		
Examiner		ultiple Gunshot Wounds le to (or as a consequence of):				Death		
xaminer	if any, leading to immediate cause. Enter Underlying Cause	te to (or as a consequence of):						
to, e be executed visician and burial - transit		AMENDED	<u> </u>					
OX 687 ath certific attending p or use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnance Live birth Pregnant at time of death Unknown		c pregnancy	23d. Date of delivery Month Da	y Year		
i, P.O. Be ires that the de signed by the Ibe detached for by the detached for by Phy	Part II. Other significant conditions	ontributing to death but not resulti	ng in the underlying cause given in Pa		o use contribute to the			
Division of Vital Records, P.O. talor Attending Physician: The law requires that the rather death. Tal Director: After this certificate has been signed by all Director: After this certificate has been signed by artification: To Be Completed by Partification: To Be Completed by P				24a. Was an autopsy performed 1 Yes 2	prior to cor death?	psy findings available inpletion of cause of		
ital Recinican: The scentificate Irrector, page	25. Was case referred to medical examiner?	spital: 1 Inpatient 2 ✓ ER/6	26.Place of Death Outpatient 3 DOA Other	(Check only one) Nursing Home 5 Res	idence 6 Other:			
on of Vit ending Physic ath. rr: After this the funeral dir	1 Yes 2 No 27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of Injury 28c. Injury at Work 1 Yes 2	28d. Describe how	injury occurred	-		
Division of To the Hospital or Attending Physhin 24 hours after death. To the Funeral Director. To the Funeral Director. To the Funeral Director. To a funeral Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, (Specify) Local Street	farm, street, factory, office building, et	or Town, State)	t and Number or Rural nue, Baltimore, Md.	Route Number, City		
29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								

State 31. Date filed (Month, Day Year) Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

29c. License number

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OUME

29d. Date signed (Month, Day, Year)

April 25, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Dorasavage April 25, 2012 4:59 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4709 Flower Valley Drive Rockville Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 199-09-7473 Hours 1 🗆 M 2 🔀 F Director 91 June 27, 1920 Pennsylvania Usual Residence of Deced 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified Maryland Montgomery Rockville 1 Yes 2 X No o 10e. Street and Number 10f. Zip Code ber 10g. Citizen of What Country? ns 23a c c must h Funeral 4709 Flower Valley Drive 20853 United States items death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Professor College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or near ٩ Prokup Workun Mary Susdansky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth J. Swanstrom/Daughter 14107 Blazey Drive, Houston, Texas 77095 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State April Montgomery Crematorium, Inc. 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Signature of Funeral Service Licenses M01305 23a. Part 1. 5 feet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Rheumatoid Arthritis Sequentially list conditions, it any cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consection confi DIVISION OF VITAL RECORDS, P.O. BOX 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed. and that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death Year the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate has page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral I Medica 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) D48043 April 26, 2012

Registrar

15

32. Registrars Signature

5530 Wisconsin Avenue, Chevy Chase, Maryland 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharon Scanlon, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 27 Day 2012 ear DiPaola, Jr. 3:47 P M Joseph Anthony Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign September 5, 1920 1**X**□M 2 □ F Director Maryland 218-05-2050 91 or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** Maryland Baltimore Timonium 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 2123 Pot Spring Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. or 1 Never Married 2 Married Completed by 1X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Photographer Baltimore Sunpapers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Raimondi Joseph A. DiPaola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i 1730 Trotting Court Jarrettsville, Md. 21084 Mr. Tony DiPaola (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Dulaney Valley Cem. Maus. 5/2/2012 4 Donation 5 Dother (Specify) Entonibment) Timonium Maryland 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road DAMA Towson, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Merran Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 → Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signate 18/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

N.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3347 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ Day 2012 Year Robert Joseph Eby 24 1:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13005 Scarlet Oak Drive Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 183-20-4119 **Director** 1 🛂 M 2 🗆 F 85 April 8,1927 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 🙀 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 23a 13005 Scarlet Oak Drive 20878 USA items? within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates 1945-49 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aerospace Engineer Private Industry Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ pe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Roy J. Eby Minnie Fulmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Karen Higgins / daughter</u> 8302 Gentle Brook Court Laurel MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 4/27/12 Woodbine, MD Signature of Faneral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Squanous Lung Cancer vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as the l attending IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Day Month Yes 2 No 1 Yes 2 Dunknown the 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed page 2 should neec 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy or Attending Physician: The Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ည 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) upletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pendina work?
1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatle Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 2 29c. License numbe 29d. Date signed (Month, Day, Year) D32407 April 25, 2012 toseph m. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D. 9707 Medical Center Drive Suite 300 Rockville, MD 20850

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

APR 3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month 1^{Day} 20°1′2 2:25 P^{M} Diane Finkelstein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Chevy Chase 8100 Connecticut Avenue 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 1 □ M 2 🏋 F 94 086-28-1280 11-4-1917 New York Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Chevy Chase Montgomery Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n ò Funeral United States 20815 8100 Connecticut Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status "natural", or iter edical Examiner Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 hand Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Sebold Becky Shechter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 East 81st Street, #10D, New York, New York 10028 1 and 2 sof Health Daughter Rhea Stein 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 5 0 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, Elmont, New York 4-19-2012 Donation 5 Other (Specify) Beth David Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Edward Sage1 1170 Rockville Pike, Rockville , Maryland 20852 Ell M00910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of) Examiner Failure To Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No
9 Unknown Month Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Plospital or Attending Plant P 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DY7928

State

31. Date filed (Month,

68760

Box

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 06-2011 Serve S. parkel

Lila Baḥadori, MD - 10301 Georgia Avenue, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlene G. Feinstein 27 2012 April 9:10P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 8. Date of Birth (Month, Day, Year, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 217-54-765 Hours Director 1 🗆 M 2 🕱 F 62 8-15-1949 MD show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Carroll MD Westminster 10e. Street and Number 0 10f. Zip Code 10a. Citizen of What Country? must be Funeral 23a 692 Skyline Way 21157 USA death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ral", or iten Examiner r 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or Completed by 1 Yes 2X No 1 ☐ Yes 2 No Specify. Specify: white 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Assistant Human Resources 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William F. Bonsall Edith Fowble traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Feinstein-son 692 Skyline Way, Westminster, MD 21157 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Page 1 cemetery, crematory or other place 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lake View Memorial 5-2-2012 Sykesville, MD permit. 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service L 254 Ε. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition *edical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events Directo for as a consection of of and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the 38 IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month ed by the at detached for Pregnant at time of death 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 les 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available has autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No. 25. Was case referred to medical examiner?

1 Yes 2 director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury М Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760 certificate be Division of Vital Records, P.O. Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifice filled in by the funeral within 2 To the 0

Baltimore, Maryland 21215-0036

29a. Certifier 🚣 🗲 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 11:54

30. Name and address of

MD 2111 MILC

31. Date filed (Month, Day Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #8 Per FH G927 5/09/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth C. Flynn Month April 2012 1:23 P M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) . Date of (Month, Day 06 Months Days Hours Min **Director** 198-22-8245 1 □ M 2 😾 F 83 1928 26, Pennsylvania May Usual Residence of Decedent show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Dunda1k 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2902 Dunmore Road 21222 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mercy Hospital Food Service Manager 12 Years 1 Year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Hurko Anthony Ciesnolevicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fort Pierce, FL 210 Hunt Ave. Joe Goshen (Grandson) 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Sacred Ht of Jesus Cem. 5/2/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Marvland 21222 Signature of Funeral Service Licensee Scott P. Gardner 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Cancer V/V= disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown ed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 🗌 Yes Hospital or Attending Physician: director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 L Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending n 24 hours after death.

• Funeral Director: A

pletely filled in by the fi Accident Suicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29b 29d. Date signed (Month, Day, Year) 2012 address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar HAR

MS

701 N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificat	e of Death		Reg	. No. 201	2 335		
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Johnny Lee Green				Date of Death Month April 23, 20	Day Year	3. Time of Death 0546 hrs		
Jakan Examine	4a. Facility Name (if not institution, give street and no	umber)	4b. City, Town, or	Location of Death	April 23, 20	4c. County of Death			
	Sinai Hospital		Baltimore						
Funeral Director	5. Social Security Number 215-76-8218 Usual Residence of Decedent	7. Age (In yrs. last birthd	Months Day			(MM/DD/YYYY) 9. Birl 1.1959 Foreig	Maryland		
any	10a. State 10b. County	10c. City, Town or			<u> </u>	-	10d. Inside City Limits		
Maryland 28a-f show any 1 at once. ector	Maryland	Baltim					1 X Yes 2 No		
th the Maryland 3a or 28a-f sh potified at onc	10e. Street and Number 3817 Granada Avenue		10f. Zip Code 21207		Ţ	. Citizen of What Cour	ntry?		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f shour other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married Armed F 1 Yes 3 Widowed 4 Divorced If Yes, Give Yea	Forces?	Was Decedent of His If Yes, specify Cubar Yes 2 X No.	n, Mexican, Puerto Ri		14. Race - Ameri White, etc.	can Indian, Black,		
ours aft atural* camine	or Dates: 15. Decedent's Education (Specify only highest gra	ide completed) 16a. De	cedent's Usual Occupa	tion (Give kind of wo		6b. Kind of Business/I	ndustry		
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu e event, the Medical Exa	Elementary/Secondary (0-12) College (1 12th grade	1_4 or 5+)	ring most of working life Me Improv	rement		Contrac	rivate tor		
215-C be filed v ntal Hygi rked oth ent, the	17. Father's Name (First, Middle, Last) Levi Green			18.Mother's Name (F Ella Ja		,			
212 nould be and Ments is mark tic even To B	19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Stree				, Zip Code)		
MD and 2 shot alth and 2 is an mati	Lenora Green/Wife		7 Granada			•			
- 트 를 을 ^그	20a. Method of Disposition 1 Burial 2 XCremation 3 Removal fi 4 Donation 5 Other Specify:	rom State crematory	Disposition (Name of ce or other place)	04-3	0-12	20c. Location - City or Baltimor	e,Md.		
	21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that of	and the death Death	22. Name and Address	sterstow	man-Ha n Rd.E	rris Fun Baltimore	eralHome, Md.21215		
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Tramad	ol Intoxicat a consequence of):		Such as cardiac of h	espiratory arres	t, shock, of fleat	Between Onset and Death		
	Sequentially list conditions, b.	a consequence or).		0.0					
ted misit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	a consequence of):							
cuted nd transit	d.								
760, icate be executed physician and the burial - transit	X UNPENDED . AMENDED	23a,pt.II,27	,28a-f,per	me,g927 5	5-30-12	Sm			
8760, tificate being physic as the buring th	23b. Was decedent pregnant in the	outcome of pregnancy birth 2	Fetal death 3	Ectopic pregnance	:v	23d. Date of delivery Month) Day Year		
, P.O. Box 687 res that the death certific signed by the attending 1 be detached for use as it d by Physician/	past 12 months? 1 Yes 2 No 9 Unknown g death Unkn	nant at time of 5	Other (Specify)				,		
that the red by the detached	Part II. Other significant conditions contributing to Acute Renal Failure ar	-			-	acco use contribute to			
Records, P.(The law requires that ficate has been signed r. page 2 should be det Completed by	Acute Renal Fallule al	id hypertens.	ive Calulov	asculat	24a. Was an		ably 4 Unknown topsy findings available		
Cords law requi has been a e 2 should	Disease				autopsy perform	prior to c	ompletion of cause of		
Vital Rec ysician: The l his certificate I director, page	25. Was case referred to medical		26.Place	e of Death (Check on	1 Yes 2	No 1 🗸 Ye	s 2 No		
Vital ysician ysician this certi this certi	examiner? 1 ✓ Yes 2 No	Inpatient 2 ER/Outp	atient 3 DOA	Other		esidence 6 Other			
on of nding Pl th. r: After ie funera	Natural 5 Pending	h, Day,Year)	40,			w injury occurred took drug			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the state death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled by the funeral director. Be Completed by Fertification: To Be Completed by Fertification:	3 Suicide 6 Could not be 28e. Place	-23-12 unkr ce of Injury - At home, farm Found at Ho	, street, factory, office t		or Town, Sta	te)Sinai Hos	ral Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier 1 Certifying Physician: To the best one) 2 Medical Examiner: On the basis	st of my knowledge, death of examination and/or inve	occurred at the time, d	ate and place, and du		s) and manner as state			
Me. S 1 ≤ 1 € S	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mor								
	30. Name and address of person who completed cau	ise of death (Item 23a)	O.C.	M.E.		April 24, 2012			
10	Victor Weedn MD JD Assistant Me	edical Examiner 90	00 W. Baltimore S	Street, Baltimore	, MD 21223				
State Registra	31. Date filed (Month, Day Year) 0 2012 32. Rd APR 3 0 2012	eg strar's Signature	faces						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland /		rtment of Hotificate of L			giene Reg. No. 20	2 3352
*	Physici /Medic		1. Decedent's Name (First, Middle, Last) ALEXANDR		al			2. Date of De. Month APRIL	Day 24, 24	ear 8.30 AM
	Examin	er	4a. Facility Name (If not institution, give s St. Martin's Home 5. Social Security Number 6. Sex	7. Age (In yrs. last i	birthday) . Yrs.	4b. City, Town, or Catonsv If Under 1 Year Months Days		8. Date of Bird (Month, Da	y, Year)	MOYE Birthplace (State or Foreign Country)
	Director Maryland 10-1 show	ctor	215-09-2299	97 10c. City, To	own or Loc	eation nthicum		11/8/	14 [Iaryland 10d. Inside City Limits 1□Yes 2)X No
36	72 hours after death with the Maryland natural; or Itams 23a or 28e-f show disal Examinational be notified at	by Funeral Director	10e. Street and Number 699 W. Maple Rd. 11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	1	10f. Zip Code 2109 Vas Decedent of His Yes, specify Cubar □ Yes 2 □ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:		10g. Citizen of Wh USA 14. Race - Black, Specify:	•
121215-0036	iled within 72 hou lygiene. her than "natura nt, lite wedfel E	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 6 17. Father's Name (First, Middle, Last)	ation 16	(Give life. [memaker	tion uring most of working 18. Mother's Name		Home	
Maryland	ould be fi Mental H arked ot atic avar	George Gruyin Paul:							ruyin	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic avant. The Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type Richard J. Guarner 20a. Method of Disposition 1. □ The Surial 2 □ Cremation 3 □ Roll 1. ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	a Jr. / Son 6	99 W of Dispos tery, cren	g Address (Street a	a) D	nicum,	Maryland 20c. Location - Ci	21090
Balti	permit. Departir Imports any inju		21. Signature of Funeral Service License		22	. Name and Address	s of Facility Lot as Ave. Ba	ıdon Pa	rk Funera	1 Home
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or compliance, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to infractible.	Due to (or as a consequence	MYC ce of):		ALIN			Approximate Interval Between Onset and Death ONIE HAUF HOUR.
68760,	icate be executed physician and s the burial-transit	edical Examine	causé, Enter Undertying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):					
P.O. Box (that the death certifica ed by the attending ph detached for use as th	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3□	Ectopic pregnancy Other (specify)			23d. Date Month	
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al Record	The ate h page	e Completed	RECURRENT US ESSENTIAL HY 25. Was case referred to medical	21 NARY TRA 1 PERTENSION	N.	INFECT		1 Tes	2 No 1	ere autopsy findings available or to completion of cause of ath? Yes 2 No
of Vii	Phys this ral dii	To B	avaminar?	ospital: 1 ☐ Inpatient 2 ☐ ER/ 28a. Date of Injury 28t	Outpatien		4 × Nursing Hor	ne 5 ☐ Resi	dence 6 Other	
Division of Vital	il or Attending Fafter death. Diractor: After if in by the funeral	Certification;	1 Statural 5 Pending investigation 3 Suicide 4 Homicide	(Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	Injury		/es 2 □No		Street and Number	or Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical C	29a. Certifier 15 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best of my knowled ter: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier				0018362			5-2012
	c.		30. Name and address of person who co Komal K. Davig 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23) M·D· 3455 32. Registrar's Signature	a) (Type,	Kens A	ve. Ste	Lio, O	Baltimo	re, md21229
*£.	Sta Registi		APR 3 0 2012	Benen B. A	back					

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Olik Olik			⊃িহ 1- For State Registrar	ate or mary		artment of rtificate of		nd Mental Hyg		g. No. 201	2 1335
Pl Medical I	hysicia Exami	an/	Decedent's Name (First, Middle		JEL ZAMUD	TO CARO	'T A	2	Date of Deat Month April 18, 2	th	3. Time of Death 0801 hrs
			4a. Facility Name (if not institution					Location of Death	April 18, 2	4c. County of Dea	
, with			6700 Belcrest Road 5. Social Security Number	6. Sex	7. Age (In yrs. I	and high days	Hyattsville	[1611-d 0411]	0 D-4 (Di-	Prince Georg	
	neral ector		NONE	1 M 2 F		32 Yrs	Months Day		March_	th(MM/DD/YYYY) 9. E Fore 24, 1980	
	, au	ı	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion				10d. Inside City Limits
rland	28a-f show d at ooce.	ğ		GEORGE	RIV	ERDALE					1X Yes 2 No
ле Маг	23a or 28a-f sho notified at ooce.	Director	10e. Street and Number 5420 56th Ave #	201			10f. Zip Code	2.7		Og. Citizen of What Co	untry?
with th	ns 23a be noti	ara	11. Marital Status	12. Was D	ecedent Ever in U.		s Decedent of Hi	spanic Origin? (Spec	ify Yes or No-		erican Indian, Black,
er death	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at occa-	Funeral	1 X Never Married 2 Mar	1 Yes				n, Mexican, Puerto Ri	, ,	White, etc.	ino
urs afte	tural"	d b	3 Widowed 4 Divo	rced If Yes, Give Y or Dates: ify only highest g				specify: MEXI		Specify: Lat	
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MD 21215-0036	ther the Medi	Completed	12 ¹¹ 17. Father's Name (First, Middle, I	_ast)		Cash	1er	18.Mother's Name (F	irst Middle M	Ice crea	m maker
215 be file	rked o	Bec			EL ZAMUD	IO MEND	IOLA	CELIA GAR			
D 21	is ma	-1	19a. Informant's Name/Relationsh			1				ber, City or Town, Sta	te, Zip Code)
e, M and 2	Health :		Elizabeth Garcia 20a. Method of Disposition	a (frien	20b. F	5420 Place of Dispos	56th Ave ition (Name of ce nerplace)	e # 301 Ri	verdal ate	e <u>MD20737</u> 20c. Location - City of	KuTown; State
MOF	r other		1 X Burial 2 Cremation 4 Donation 5 Other Spe		from State Mcp	crematory or oth al Ario	de Rosa	ales 05/4/	12	Morelia, M	
Baltimore,	nporta	1	21. Signature of Funeral Service L			22. N	ame and Address	s of Facility Sant	a Cruz	Funeral S	ervices, Inc
Phys		4	23a. Part I. Enter the disease, or c	omplications that	t caused the death.	600 Do not enter th	Kennedy	ST, NW,:	Washin	gton, DC 2	0011 Approximate Interval
/Me	dical niner		failure. List only one cause o Immediate Cause (Final disease				, ,				Between Onset and Death
Kai	liller		or condition resulting in death)	Due to (or as	a consequence of	f):					
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OX (for use	Sici	1 Yes 2 No 9 Unkn		gnant at time of dea mown	ath 5 Oth	ner (Specify)				
O. B	d by the		Part II. Other significant conditio	_		esulting in the u	nderlying cause g	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. and or Attending Physician: The law requires that the analysis of the law requires that the second south.	n signe d be de	ed by								2 No 3 Pro	bably 4 Unknown
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Rec : The l	ficate r, page		75 M						1 ✓ Yes 2		es 2 No
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of V	After thuneral	\vdash	27. Manner of Death	28a. Dat	te of Injury oth, Day,Year)	28b. Time of Ir	ijury 28c. Inju	ry at Work? 28	d. Describe h	ow injury occurred	
Sion	ctor:	catio	1 Natural 5 Pendir 2 Accident Investi	gation	4-18-12	fd 7:48	am			hanged se	
Divi	al Dir	Certification:	3 X Suicide 6 Could determ	not be 286. Pla nined (Specifi	ace of Injury - At ho stairw buildi	ell of a	t, factory, office to apartmen	ulding, etc. 28	t Location (St or Town, Sta	treet and Number or R ate) 6700 Belc Llle, MD.	ural Route Number, City rest Rd.
Division of Vital Records, P.O. Box	whall as hours after usual. To the Fuoeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Phy	sician: To the b	est of my knowledg	ge, death occurr		ate and place, and du	e to the cause	e(s) and manner as sta	
To t	Tot	ᄝ	29b. Signature and title of certifier	and manner			29c. Licens			29d. Date signed (Mo	
			lis com				O.C.I	M.E.		April 19, 2012	
hugas			30. Name and address of person w Ling Li, MD Assistant		,	•	e Street, Balt	imore, MD 2122	3		

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 19^{Day} April Physician/ 2012 2:15 P.M <u>ee David Hillegass</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village Carroll Westminster 6. Sex 1 X M 2 □ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Augus to 1918 Pennsylvania 184-16-7056 93 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown injury or other traumatic event, the Medical Examiner must be notified at one. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Martinsburg 1 X Yes 2 □ No Pennsylvahia Blair 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16662 U.S.A. 400 Forshey Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces: þ 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Full Service Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Station Service Station Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma V. Fair Harry C. Hillegass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aimee A. Schultz 1237 Arnold Road, Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Schellsburg. Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4-24-12 Schellsburg Cemetery |Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 21214 mas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ 9 tec e ta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Dui to (or as a nunsequence of) cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has blirector, page 2 s autopsy perform death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? iniury 1 X Natural 5 Pending 2 🗌 No Accident
Suicide Investigation within 24 hours after dear To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

(Check only one

31. Date filed Worth,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

349 Malcolm Rd. WestminsterMD 21157

30,2015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2012 12:20A M Samuel Frank Howard 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Golden Living Center Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220-03-1318 93 Hours 1 M 2 □ F Director 2-21-1919 MD Usual Residence of Dece 28a-f show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD Carroll 1 Tes 2 No Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral 1211 N. Main St. 21074 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tool Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Howard Pearl Tracev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 Barbara M. Bolt-daughter 4320 Millers Station Rd., Manchester, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Poplar Grove Cem. 5-1-2012 |Phoenix,MD of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 7) 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Caronomi Immediate Cause (Final Onset and Death Wingestwe Physician/ 41 disease or condition Medical resulting in death) Due to (ous a consequence of): Examiner Esque thally not so citions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last burial-transi nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed's Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier Date signed (Month, Day, Year) 2012

State Registrar Stoner

21157

Westminster

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201v 201v2 Physician/ AMOUT 11 Hardy 8:23 pm Larry Donell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
District Heights Examiner Prince George; s Marlboro Pike Social Security Number 577–88–2985 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct • 9 9. Birthplace (State or Foreign Sex 1 X M 2 □ F **Funeral** Months Days Hours Min. Maryland 1959 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director District Heights Y Yes 2 No MD Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 United States Pike 8014 Marlboro 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married Completed by Maryland 21215-0036 Specify Black 1 Yes 2 X No Specify: If Yes, Give 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Labor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bertha Estelle Windsor William Joseph Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) R. Pinkney Southview Dr. Oxon Hill Md. 20745 Taschima Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Riverdale Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 1/12 Riverdale; Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2504 28th Steet Bonnette & Associates Washington, DC20018 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical adenocacinen Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No detached 9 Unknown n signed by tl Id be detach∈ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an las l completed filled in by the funeral director, page 2 autopsy perform death? this certificate I 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 I ER/Outpatient 3 I DCA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No death Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 23^{Day} Blanche 2012 Hurwitz 5:34 P_M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery ocial Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 053-18-5633 Days Min Director 1 . M 2 K F 91 September 3, 1920 New York Usual Residence of Decedent 28a-f shov items 23a or 28a-t sno ner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 9324 Harvey Road 20910 United States within 72 hours after death "natural", or iterr edical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. United States Elementary/Secondary (0-12) College (1-4 or 5+) Mathematical Statistician Government event, 1 Be and 2 should be filed 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever Rudo1ph Skalak Tuma Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Sirken / Son 9324 Harvey Road, Silver Spring, Maryland 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 a 20c. Location - City or Town, State of . April Pate 29 1 Burial 2 X Cremation 3 Removal from State ō Department Important: I any injury or once. Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Fune al Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 ingelettel M01305 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions. Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) No Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe Pleural Effusions Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law I 24 hours after death. has page 2 autopsy perform this certificate 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one. examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 K ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending work n 24 hours after death.

Per Funeral Director; Al oletely filled in by the fi Accident Investigation 1 Yes 2 No 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the the only one and title of dertifier 29b. Signatu 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

5

30. Name and address of

31. Date filed (Month, Day, Year)

Carmita Gobern, MD

3 0 2012

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

D0054012

8600 Old Georgetown Road, Bethesda, Maryland 20814

April 24, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	partment of Health and leartificate of Death			358					
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Dea							
	sicia Iedic		Margurite B. Jackson		Month April	26, 2012 2:40 A						
	amin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1 2 2	4c. County of Death						
Fune	oral		15706 Saint Thomas Church Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Upper Marlboro If Under 1 Year If Under 24 Hrs.	■ 8. Date of Birth	Prince George's 9. Birthplace (State or F	Oreion					
Direc	ctor		214-36-0144 Usual Residence of Decedent 1 □ M 2 [XF 72 Yrs.	Months Days Hours Min.	(Month, Day Feb 25	(Year) Country)	oreign					
/land f shov	ed at	tor	10a. State 10b. County 10c. City, Town or			10d. Inside City	Limits					
e Mary	notifie	Director	MD Prince George's Upper Ma			1 □ Yes 2	X No					
with th	st pe		15706 Saint Thomas Church Road	10f. Zip Code 20772		10g. Citizen of What Country? USA						
death items	Jer m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,						
336 after al", or	xamii	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:	7 110411, 0101,	Black, White, etc. Specify: Black						
5-0 hours	dical	olete	15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/Industry						
121 thin 72 sne. than '	Je Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) life.	e kind of work done during most of worl DO NOT use retired) netologist	Cosmetology							
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho	rent, ti	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, I							
Maryland should be file and Mental I is marked o	atic ev	욘	James Bennett		e Anders							
	er traum					City or Town, State, Zip Code) 2077 Upper Marlboro, MD						
			The Burnar P and Grothlation of the Front State C	position (Name of ematory or other place) urney Crematory 04,	Date /28/12	20c. Location - City or Town, State Woodbine, MD						
Baltimo permit. Page Department Important: It	y injury											
u ääs:	MOIZST BEVERTY L. HECKFOLLE, P.A. CIAIRSVIIIE, MD 21029											
23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or cardiation)												
Medi	ical		disease or condition resulting in death) a. Pacceatic Cance Due to (or as a consequence of):				-1					
Exami		<u>_</u>	Sequentially list conditions, b. Liver Metastasis									
ted	IISII	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Uniderlying Cause (Disease or injury									
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certifical nding pt	nsa as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery						
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that the ned by t	nelac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to the cause of deat	:h?					
dS, I quires I					1 □ Y	es 2X No 3 ☐ Probably 4 ☐ Unl	known					
VITAI KECOITAS, ysician: The law requires is certificate has been sign director page 2 should be	2 0 0	Completed			24a. Was a autops	sy prior to completion of caus	ilable se of					
III HECO sician: The law i certificate has b	r, pag	-	25. Was case referred to medical		1 Yes							
VITA ysicial ysicial s certif		To Be	examiner? 1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Death (Chec		ence 6 Other (Specify)	\neg					
Of ng Ph fter thi	<u> </u>		27. Manner of Death 1 XNatural 5 Pending (Month, Day, Year) 28b. Time injury			ow injury occurred						
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DIVISION tal or Attendir rs after death. al Director: Afed in by the fu		28e. Place of Injury - At home, farm, street, factory, office determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28c. Place of Injury - At home, farm, street, factory, office City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
DIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certificant representation or the funeral director.	letely illi											
To the	dilios	2	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)						
			Me Com Coshins, MD	D43162		April 27, 2012						
5	$\sqrt{}$		30. Name and address of person who completed cause of death (Item 23a) (Type Melvin W. Gaskins, M.D. 7831 Bellk I		⊦. MD 20'	770						
	State istra		31. Date filed (Month, Day, Year) APR 3 0 2012 32 Registrar's Signature.		C, EID 20	,,,						
			1/24									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Day Physician/ Month organ 26 2012 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 304 Neale Court Carrol1 Sykesville . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days Min. Oct 12 1**X** M 2 □ F 61 013-40-2174 1950 MD Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director MD Carroll Sykesville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 items 23a Funeral 304 Neale Court USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S.

Armed Forces?

IV 1etnam

If Yes, Give

Year or Dates. Black, White, etc. , or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Specify: white Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Amatal Hyglene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President of Operations | Knorr Brake Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barbara Peltier Joseph Kmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Neale Ct., Sykesville, MD 21784 Mr. Nicholas Kmon (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4-27-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 phy. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) Month Day signed by the a P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 🗷 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY g926 4/30/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 11aM 04 12:01 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 118 Broadway Street, Apt. Hagerstown Washington 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Days Min. Day, Year) 579-56-9026 1 M 2 D F **Director** 0 Washington, DC show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🖔 Yes 2 🗌 No MD Washington Hagerstown r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral 118 Broadway Street, Apt. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Yes 2 No If Yes, Give Year or Dates. 1 X Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Mechanic Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental F 27 is marked or r traumatic even ge 1 and 2 should be fil nt of Health and Mental t: If item 27 is marked မ Eleanor Woods Frank Andrew Kurtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hagerstown, MD 21740 <u>Lori Gaither / Fiance</u> 118 Broadway Street, Apt. altimore, other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 🗌 Burial 2 🗀 Cremation 3 🗆 Removal from State injury or Department of Important; If any injury or once, 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04/18/2012 | Hanover, Maryland Signature of Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition en work Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami and burial-trar resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforr within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home XX Residence 6 - Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of perifier 29d. Date signed (Month, Day, Year) Ezz D35497 4-17-2012 3ul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1122 OPAL CT. HAGERSTOWN MD 21740 State

Registrar

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			State Registrar	+ +4:-1:-11	41		Cer	tificate	e of L	Death			Reg. No	. 21) 2		336
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روستان الموس	Medi Examii		4a. Facility Name (if not in)				Location o		-	4c.	. County	of Death	 V	
	Funeral Director		5. Social Security Numbe 577-60-4597 227-70-948 Usual Residence of Dec	f 6. Se		Age (In yrs. Ia	st birthday) Yrs.			If Under Hours	24 Hrs.	8. Date of Bi (Month, D Mar 9,	rth			lace (State	or Foreigr
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	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 901 Arcola	Avenue				10f. Zip					10g. Cit	tizen of V	Vhat Count	try?	
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 3 ▼ Widowed 4 □		12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	s? X No	If	Yes, spec	ify Cuba		, Puerto	ecify Yes or No Rican, etc.)		Black	e - America k, White, e Whit e	tc.	
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, Mary	nd 2 should salth and N n 27 is ma er traumai		19a. Informant's Name/F				1					Nuffield	-			ode)	
Baltimore,	Page 1 arment of Hetant: If iter		20a. Method of Disposition 1 □ Burial 2 🛣 Cr 4 □ Donation 5 □	emation 3 🗌		te ce	ace of Dispos	ition (Nam atory or ot	e of her plac	е)		Date /28/12	20c. Lc	ocation -	City or Tov		
ľ			21. Signature of Funeraly 23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final	HH sease, or comp	lications that caus	MO125 sed the death ine.	1 Be	verl	<u> </u>	Heck	rott	on Servi e, P.A.	Cla	P.O. rksv	Box zille	784 MD Approxima Interval Be Onset and	ate etween
	Medical Examiner i physician and Examiner as the burial-transit		disease or condition resulting in death) Sequentially list condition for your leading to in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns,	Due to (or a	s a consequi	encu <u>4</u>):	ardio	ovaso	cutar	DIS	ease				year	<u>S</u>
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.		IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 【XNo 9 ☐ Unknown	ICITIL 1	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 ☐ Fetal tat time of de	death 3 🗌	Ectopic p Other (sp		у				23d. Dati Mor	e of delive	ry Day	Year
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f Vital	Physician: this certific ral director,	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 XNo 27. Manner of Death	1.0	Hospital: 1 X Inpa 28a. Date of in		ER/Outpatient			4 L. Nu	rsing Ho	me 5 🗌 Resi					
Division of Vital Records, P.O. Box 687	al or Attending s after death. Il Director: After ed in by the fune	Certificat	1 A Natural 5 2 Accident	Pending Investigation Could not be determined	(Month, E	Day, Year)	injury	м	work'		No	28d. Describe 28f. Location (City or To	Street and	d Numbe		Route Num	ber,
	To the Hospi within 24 hour To the Funer: completely fill	Medical	(Check 2 ☐ M only one) 3 ☐ C 29b. Signature and title o	edical Examir ertifying Nurs certifier	ician: To the best of the practitioner: To the basis of the Practitioner: To	f examination	and/or investi	gation, in n death occu 29c.	y opinio	n, death oc ne time, dat number	curred at	the time, date	and place, the cause 29d. Dat	and due (s) and m e signed	to the caus	se(s) and m ated. ay, Year)	anner state
	3 √		30. Name and address of Shyamsundar	person who co	ompleted cause of			int)			ver	Spring,					

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Car) (30 2012 32. Refistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04^{Month} 2012 AGNES MARLYN KACZMARCZYK 24 6:42 Ρм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Pasadena 206 Chelsea Rd If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 218 30 5109 Director 1 🗆 M 2 🗙 F 77 1934 01 Maryland Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Chelsea Rd 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Import/Export Accountant injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or con-ည Andrew Michael Eder Josephine M. Durka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Kaczmarczyk - Son Earle Branch Rd Centerville, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/28/2012 Baltimore, MD Holy Rosary Cem 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of uneral 86 me Licensee 169 Riviera Dr Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweep Onset and Death Immediate Cause (Final Physician/ HYDRA Medical resulting in death) Due to (or as a co equence of) Examiner WEEH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine OBSTRUCTION BOWEC 78K use as the burial-transi Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Pospital or Attending Physician: The law requires that the death 24 hours after death.
Phones after death.
Funeral Director, After this certificate has been signed by the atternal Director. in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ned by the a e detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral Mary of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation completely filled in by the 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0002,703

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State

Registrar

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32. Registrar's Signatur

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Pased

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Per ANA BD G926 4/30/2012 Ib State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar			, ,	Cer	tificat	e of D	eath			Reg. No.	201	2 3	363
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Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. This marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Potocial Dispositor	14 J Ric					101. 21	2077	70			rug. Gitiz	USA	ountry :	
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13-P	to to la mo	(Spec	15. Decedent's l cify only highest g	ade completed)		16a. Deced	dent's Usu kind of wo O NOT use	rk done d	ition <i>urin</i> g <i>m</i> os	at of work	<i>in</i> g	16b. Kin	d of Business	/Industry	
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Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygleine. Important If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	F	William	Henry Ga	ates					Mi	nnie	Lee Ma	ples			
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Division of Vital Records, P.O. Box 63 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Cipol	(Check 2 only one) 3	☐ Medical Exam ☐ Certifying Nu	nîner: On the basi	s of examination	and/or inves	tigation, in	my opinio	n, death c	occurred a	t the time, date	and place, a	and due to the	cause(s) and ma	nner stated.
To the voithing complete the co		29b. Signature and	title of certifier	D 1.	ot:		1	c. License				29d. Date	signed (Mont	h, Day, Year)	
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		30. Name and add							T	m o 1 1	VID 2072	3	-		
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	State strar		7K 3 U 20	12 Dens	egistrar's Signa	ure A C	Ked								

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physician	1/	1. Decedent's Name		·							2. Date of Domestin April	Г	2012	Year	3. Time of Death 6:15 AM M
Medica Examine		4a. Facility Name (if	th F. Lo		ber)		4b. City, Tov	wn, or L	Location	of Death	APLII		lc. County	of Death	0.13 AH
		3208 Ca	lvert Bl						ısby				CA1v	ert	
Funeral Director		5. Social Security No. 265-48-2 Usual Residence of		Sex I□M2 X F	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 \ Months D	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Feb 16	ay, Year		Cour	place (State or Foreign ntry) achusetts
f show	ģ	10a. State	10b. County	·	10c. Ci	ty, Town or Lo	ocation			,	<u>' </u>				10d. Inside City Limits
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with th	al l		alvert Bl	vd			10f. Zip Co	0651	7			10g. (USA	What Coul	ntry?
ter o	ed by Funeral	11. Marital Status	ied 2 🗌 Married	12. Was Decer Armed For 1 Yes If Yes, Give Year or Da	ces? 2X No		Was Decedent If Yes, specify 1 Yes 2	t of His Cuban	panic Ori , Mexical	n, Puerto	ecify Yes or No Rican, etc.)	-		ck, White,	
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within 72 giene. er than the Me	Completed	Elementary/Seco		College (1-	4 or 5+) 5+		OO NOT use ret		iiig moo	CO WONG	, ig	adn	ninis	trat	ion
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d 2 should alth and N 27 is ma er traumat		19a. Informant's Na Harry A	ame/Relationship (rother	19b. Maili 105	ing Address (St Hayes F	treet an	nd Numbe	er or Rura lbury	NH 0	er, City 3823	or Town, S	State, Zip (Code)
permit. Page 1 an Department of He Important: If item any injury or othe once.			position Cremation 3 [5 Cher (Spec				osition (Name o matory or othe)	1	Date	20c.	Location ·	- City or To	own, State
permit. Departr Importa any inju		21. Signature of Fur	neral Service Licen		irecto		State A					W. I	Balti	more	Street
hysician/ Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)		one cause on eac	aused the dear ch line. MCER or as a conseq	th. Do not ent	er the mode of	f dying,	such as	cardiac c	or respiratory a		CK		Approximate Interval Between Onset and Death
ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events	nmediate rlying injury	b. Due to (d	or as a conseq	uence of):									
6 E E	- 1	resulting in death) l		Due to (d	or as a conseq	uence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	~	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		3irth 2 ☐ Fet nant at time of	al death 3	Ectopic preg							ate of deliver	ery Day Year
res that the signed by Id be deta		Part II. Other signif	icant conditions of	_		sulting in the	underlying caus	se give	n in Part	I.					he cause of death?
he law requate has beer bage 2 shou	Completed by	HYPO	OTHYR	OIDI	SM						24a. Was auto perf 1 \(\sum \) Yes	opsy ormed?		Were auto prior to co death? 1 ☐ Yes	psy findings available impletion of cause of
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or Atten after deat Director: d in by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigatio 6 Could not be determined	28e. Place	of Injury - At hog, etc. (Specif					_	28f. Location (City or To			er or Rurai	l Route Number,
ne Hospita n 24 hours ne Funeral pletely fille	Medical	(Check 2	Certifying Phy	iner: On the basi	s of examinatio	n and/or inves	stigation, in my	opinion.	, death or	ccurred at	the time, date	and place	ce, and due	e to the ca	use(s) and manner stated.
Nothing the confidence of the		29b. Signature and t	title of certifier	. , M.	D	-		cense r		788	S			d (Month,	Day, Year)
		30. Name and addre	ess of person who		e of death (Item	1 23a) (Type,	Print) TR	UE	MA	4 R	d,50				D-20688
State Registra		31. Date filed (Month	h, Day, Year)		egistrar's Signa		Lucy		A	ha	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 13365 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 26, . 20<u>12</u> Physician/ Cheryl Ann Lewis 5:45 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min Director 216-84-5153 1 M 2 X F 11-20-1961 50 Maryland Usual Residence of Decede or 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXNo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 218 Pinewood Drive 21122 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2xx Married 2XXNo 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: an "natural", Medical Exar 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Company 12 <u>Account Analyst</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gary Joseph Bowen Frances Carol Brown Department of Health and Important: If item 27 is m. any injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Wayne Lewis, Jr. - spouse 218 Pinewood Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 05-02-2012 | Elkridge, Maryland 21. Signatur Funeral Service 22. Name and Address of Facility Gary L. kaufman Funeral Home at Inc, 7250 Wash. Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final auger Physician/ disease or condition Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that the death certificate be executed pue burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) Live Birth 2 L recass in the past 12 months? g Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1

Yes 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director. After this certificate homeletely filled in by the funeral director, pag 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 K Natural 5 Pending injury 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2ga Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier D72139 address of person who completed cause of death (Item 23a) (Type, Print) 15V Ballimore MD 21204.

State Registrar ABBAS

6701 N

32. Registrar's Stgnature

Charles St. Such 4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2012 1:53 PM Everette David Lee April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Prince George's Laure Date of (Month, Day 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2 □ F Months Hours Day, Yea Virginia Director 225-52-8206 1941 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 USA 733 Sligo Avenue #102 items Page 1 and 2 should be filled within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify "natural" Completed 3 X Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Contractor Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Everette David Maggie Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother Ronald Nottingham, Sr. in law 2701 St. Moritz Ct. Richmond, VA 23224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 04/27/12 Woodbine, MD Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Bilateral Onset and Death Immediate Cause (Final Preumonia Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Rena burial-transit and attending physician for use as the buria Physician/Medical certificate be ardiomy Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Pregnant at time of death Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown after death. I **Director:** After this certificate has been signal of a should I Completed Severe Metabolic Acidosis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No or Attending Physician: 25. Was case referred to medica filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No Other: Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npleted 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

George I.

Laurel Regional Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKang, M.D.

D41248

7300 Van

23.

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2012

			FOR	tate of Maryland				Mental Hy	giene		
			State Registrar		Cer	tificate of D	Death		Reg. No. 20	12	3361
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
٠.,	Medic	al		awn	-			April	21 2	012	10:15P ^M
*	Examin	er	4a. Facility Name (if not institution, give street		:	4b. City, Town, or			4c. County o		i ale
	Funeral		4992 Linganore Wood: 5. Social Security Number 6. Sex	7. Age (In yrs. la:	st birthday)	Monr If Under 1 Year		8. Date of Bir	th	eder 9. Birthpl	ace (State or Foreign
	Director		217-48-3009 1 D M		64 Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Counti	y)
	MC T		Usual Residence of Decedent				<u> </u>	Aug. I	9, 1947		ington,D.C.
	ryland -f she ed at	Director	10a. State 10b. County		, Town or Loc					110	ld. Inside City Limits 1 ☐ Yes 2X No
	e Mau r 28a notifi	Dire	Maryland Frederic	ck	Mo	nrovia 10f. Zip Code		- Т	10g. Citizen of WI	ant Count	
	rith th	la	4992 Linganore 1	Jooda Dr			21770		U.S.		ry :
	ems sr mu	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S		as Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-			n Indian,
9	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 Never Married 2 X Married 1	rmed Forces? ☐ Yes 2 🔀 No Yes, Give		Yes, specify Cubar ☐ Yes 2 🔀 No		Rican, etc.)		, White, e	tc.
Maryland 21215-0036	ours a tural' al Ex	Completed by	3 U Widowed 4 U Divorced	ear or Dates.					Specify:		White
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72	vithin plene. er tha the N		Elementary/Secondary (0-12) C	ollege (1-4 or 5+) 2		NOT use retired)		tudies	Federa	il ao	vernment
٦	l be filed v lental Hyg rked othe tic event,	Be	17. Father's Name (First, Middle, Last)				-	ne (First, Middle,	, Maiden Surname)		
<u>Var</u>	ild be fil Mental narked o	2	Charles Bird				Vanis 1	Dalmus			
lar	should and Me is mar raumati	- 6	19a. Informant's Name/Relationship (Type, Pa	·	T .				er, City or Town, Sta		
	1 and 2 s of Health item 27 other tra		Thomas E. Lawn/ hus] 20a. Method of Disposition			Linganor	e Woods i		onrovia,		
Baltimore,	. 0		1 ☐ Burial 2 🔀 Cremation 3 ☐ Remo	oval from State	emetery, crem	sition (Name of natory or other place		Date	20c. Location - 0	-	
틒	permit. Page Department (Important: If any injury or once,		4 Donation 5 Other (Specify) 21. Signal re of Funeral Service Licensee	A11		Cremati		4/2012			
8	permit. Departin Imports any inju		I love & x	nother		O. Box 2			Funeral H		P.A.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause								Approximate Interval Between
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	Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):						1201
	LAUTITICI	er	Sequentially list conditions, b. —	11 40 7 00 00 00 00 00	******					-	
	ed nsit	Examiner	ar any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence on.						
	ate be executed ohysician and the burial-transit	Exa	that initiated events c. — resulting in death) Last	Due to (or as a consequent	ence of):			-			· · ·
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6876	tificating ph	Mec	IF FEMALE:			107-					-
9 X	th cer ttendii or use	ian/	23b. Was decedent pregnant 23c.	yes, outcome of pregnar	I death 3	Ectopic pregnanc	у		23d. Date Mon		y Day Year
Box	requires that the death certific been signed by the attending I should be detached for use as	Physician/Me		☐ Pregnant at time of d ☐ Unknown	eath 5∟	Other (specify)			Wolf		Suy Total
P.O.	hat th ed by detac		Part II. Other significant conditions contribu	uting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	tobacco use contrib	oute to the	e cause of death?
	uires t n sign Ild be	Completed by						1 🗆	Yes 2 No	B 🗆 Prob	ably 4 Unknown
Records,	w requ	olete						24a. Was		ere autop	sy findings available
3ec	sician: The law i certificate has k lirector, page 2 s	mo							ormed? de	eath?	npletion of cause of
	ian: T	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec				
5	hysic his ce al dire	은	1 ☐ Yes 2 No	1 Inpatient 2 I			4 L Nursing H		idence 6 🗆 Other		
סר	ling P. After t	Certificate:	1 X Natural 5 ☐ Pending	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work		28d. Describe	how injury occurred	i	
Sioi	Attenc death ctor: ,y the	rific	Accident Investigation 3 Suicide 6 Could not be	Be. Place of Injury - At ho	me, farm, stre		tes 2 LINO	28f. Location (Street and Number	or Rural i	Route Number.
Division of Vital	al or A s after il Dire		4 Homicide determined	building, etc. (Specify)		,		City or To			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: C								
	the Lithin 24	Me	only one) 3 Certifying Nurse Pra			death occurred at the	he time, date and p		the cause(s) and ma	nner as st	ated.
	₽ .≱ 6 8		29b. Signature and title chartifler	0. 1	111	29c. License	OIOU/		29d. Date signed	IVIOLITA, D	ay, rear)
,			30. Name and address of person who comple	eted cause of death (Item	23a) (Type, P	rint)	3/07		1100	100	116
			Eric Bush M	2D. 516 TR	SIA	ve fo	reder	ick,	m) 21	70	2
	Sta		31. Date filed (Month, Day, Year)	37 Registrar's Signati	ure						
	Registr	ar	APR 3 0 2012	Chave A	par	Kel		_			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 Sarah Virginia Littleton PM 26 8:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 215-24-2691 **Director** 1 🗆 M 2 🗶 F 83 June 19, 1928 Maryland Usual Residence of Decede 28a-f shov 10a. State 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits Director MD. Baltimore 1 Yes 2 X No Timonium 10e. Street and Numbe ò 10f. Zip Code rms 23a or 10a. Citizen of What Country? Funeral 2525 Pot Spring Rd. AL320 21093 USA er than "natural", or items the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julia Stevens William Tilghman Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Theuns/ Daughter 3006 Franklins Chance Dr. Fallston, MD. 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 5-1-12 Timonium, MD. 4 \square Donation, δ \square Other (Specify) 22. Name and Addre Ruck Towson Funeral Home, 21. Signature of Ineral Se 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listionly one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Keu Physician/ disease or condition Medical resulting in death) **Examiner** Securitielly list no offices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending above. attending physician and I for use as the burial-transi Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 🗌 No 1 Tyes Division of Vital 25. Was case referred to medica completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 10 Other: 4 🗆 Nursing Home 5 🗀 Residence 6 🗡 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10 M

(Check only one 29b. Signatur

Suite 4105 Charles Street Baltimore ND 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 3 0 2012

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED Q. ABBAS MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

21204

29c. License number

D72139

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 26 2012 9:26 AMM 4b. City. Town, or Location of Death 4c. County of Death Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Hours 11/27/1926 North Carolina 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🗓 No Specify: Specify Native American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) Clara Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12 Holly Springs Ct. Nottingham, Maryland 21236 20c. Location - City or Town, State 04/30/2012 Baltimore, Maryland 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23d. Date of delivery Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 2 No death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Franks M.D. 4/26/2012 Sabnna Krati D006564+ leted cause of death (Item 23a) (Type, Print) 500 Upper Chesapeuke Drive Bel Air, MD Sabrina Kratz Franks MD 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

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			Registrar Decedent's Name	e (First, Middl	e, Last)							2. Date of De	eath			3. Time of Dea	ath
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5	_Aumin		Future	Care I	ochearn			Ва	ltimo	ore							
	Funeral		5. Social Security N	lumber	6. Sex	7. Age (In	yrs. last birthday) If Und Month	er 1 Year s Days	If Und	er 24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)		9. Birthpl Coun	ace (State or Fo	oreign
	Director		220-52-5	5053	1 □ M 2 🔀 F	91	Yrs.	Inontri	- Dayo	1.00.0		Nov 16	, 19	20	Cub		
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0	ne de the a	sic	1 ☐ Yes 2 [9 ☐ Unknown	□No	4⊟Pre	gnant at time nown	e or death s	∪uner	(specify) _								
Division or Vital Records, P.O.	Attending Physician: The law requires that the death certific refath. ector: After this certificate has been signed by the attending poy the funeral director, page 2 should be detached for use as	유	Part II. Other signi	ificant condit	ions contributing to	death but no	ot resulting in the	underlyin	g cause gi	ven in Pa	urt I.	23e. Did	tobacco	use contri	bute to the	ne cause of dear	th?
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<u>.</u> 0	ndin ith. r: Aft	atio	1 ₩Natural 2 ☐ Accident	5 ☐ Pendi invest	ng (///c igation	mar, Day 10	ar) Injury	М		Yes 2	□No						
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	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier (Check only one)		ng Physician: To to I Examiner: On the and ma		amination and/or										
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	Regist	uci		11 00													

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2116 05 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Shock Trauma timure 9. Birthplace (State or Foreign Country) unk 5. Social Security Numberunk 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Hours Director 1 🔀 M 2 🗆 F Yrs DEc 8, 1965 46 Usual Residence of Dece 28a-f shov 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location Director notified 1 X Yes 2 No Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n unk Funeral 210 Guilford Avenue 21201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: mexican hispanic If Yes, Give 'natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk unk 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) event, th Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 22 S. Green Street Baltimore, MD 21201 UMMS Shock Trauma 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Ætate 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street of Funeral Se rector <u>Baltimore.</u> MĎ 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each lin Interval Between Onset and Death immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of): **Examiner** Sequentially list conditions, Examine any, leading to influedate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 the 23d. Datebordelivery attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the should be detached g 🗌 Unknown Unknown 23e Rigital robacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy performe death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No မ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 X Accident 5 Pending 1 Yes 2 No Investigation 12017 ~2000 after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) ģ 4 Homicide determined in 24 hours the Funeral Dire building, etc. 210 ltmare Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar 1. Date filed (Month, Day, Year)

APR 30

DHMH 17 Rev 06-2011

225.

2120

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #9 Per ANA BD G926 4/30/2012 JH State of Maryland / Department of Health and Mental Hygiene 2012 13372 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16, Day 2012 James Alfred Meadows 3:30 PM M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 836 Whispering Pine Circle Lusby Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 16, 1929 9. Lithare State or Foreign Days Hours 308-26-5387 1 X M 2 □ F 83 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

Physician/ Medical **Examiner Funeral Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. ctor Baltimore, Maryland 21215-0036

For State Registrar

10a. State

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To

Division of Vital Records, P.O. Box 68760

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	10e. Street and Nun					10f. Zip Code			10g. C	Citizen of What Co	ountry?
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Completed by Funeral Direct	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ried 2 🔀 Married 4 🗆 Divorced	12. Was Decedent E Armed Forces? 1 Pyes 2 If Yes, Give Year or Dates.		If Ye	s Decedent of Fes, specify Cuba Yes 2 💢 No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit Specify: W	
ete	-	15. Decedent's E			Deceden	t's Usual Occup	nation		4.05	Kind of Dools	
Compl	Elementary/Seco 12	ondary (0-12)	College (1-4 or 5		(Give kind	d of work done IOT use retired)	during most of wo	orking		Kind of Business, tertainm	·
lo Be	17. Father's Name (F		min Meadow	/s				ame (First, Middle, sther P1	Maider		
ģ	19a. Informant's Na	ame/Relationship (7)	ype, Print)	198	o. Mailing A	Address (Street	and Number or Ri	ural Route Numbe	er, City o	nr Town, State, Zij	o Code)
	Martha (C. Meadow	s/spouse	8	36 WI	nisperi:	ng Pine	Circle L	usby	v. MD 2	0657
			Removal from State	20b. Place o	of Disposition			Date		ocation - City or	
21. Signatur or moral Service Lice see rector St. Name and Address of Facility Board 655 W. Baltimore Anatomy Board 655 W. Baltimore MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								ltimore	Street		
	23a. Part 1. Enter the shock, of hear Immediate Cause (findisease or condition resulting in death)	rt failure. List only o Final	ne cause on each line a.	the death. Do n	tic	Call	1 0 40	c or respiratory ar			Approximate Interval Between Onset and Death
dical Examiner	Sequentially list cor if any so that cause. Enter Under Cause (Disease or i that intilated events resulting in death) L	rlying injury	c	consequence							
ilysiciali/ INIC	IF FEMALE: 23b. Was decedent print the past 12 mr 1 Yes 2 9 Unknown	months?	23c. If yes, outcome of 1 ☐ Live Birth of 1 ☐ Pregnant at 1 ☐ Unknown	2 🗌 Fetal death	n 3 🗆 Ec 5 🗆 O	ctopic pregnand ther (specify)	sy .			23d. Date of del Month	ivery Day Year
וכח ווא ב	Part II. Other signifi	icant conditions co	ontributing to death bu	ut not resulting i	in the unde	erlying cause give	ven in Part I.				the cause of death?
								24a. Was autor perfo 1 Yes	sy rmed?	prior to death?	topsy findings available completion of cause of 2 \square No
8	25. Was case referre examiner?	. 1	Hospital:			1	ace of Death (Che	eck only one)			
1 Inpatient 2 ER/Outpatient 3 DCA Other 4 Nursin 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Yes 2 No No No No No No No							er: 4 Nursing I	lome 5 Resid	lence (6 Other (Speci	ffy)
							/ at ? Yes 2 □ No	28d. Describe h	ow injur	y occurred	
	4 🗌 Homicide	determined	building, etc.	(Specify)				City or Tow	n, State)	al Route Number,
	(Check 2	Medical Examination	sician: To the best of r ner: On the basis of ex practitioner: To the	amination and/o	r investigat	ion, in my opinic	n. death occurred	at the time, date a	nd place	and due to the c	ause(s) and manner stated
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								, Day, Year)			
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State

Registrar

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APR 30

31. Date filed (Month, Day, Year)

aura 12-02792 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNKUNK Mason 2012 13373 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Da April 9, 2012 **Medical Examiner** 1305 hrs Laura Mason 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 400 North Haven Street **Baltimore Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Director Months Days Hours Min 213-11-0680 26 2X F 1___M Nov 22, 1985 Countr Maryland Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "...

jury or other traum.": 1 X Yes 2 No MD Baltimore Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 N. Haven Street 21224 USA Funeral 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. Yes 2 X No 3 Widowed Divorced f Yes, Give Yea Specify: white 1 Yes 2 No specify: ≦ 16a. Decedent's Usual Occupation (Give kind of work done unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed unk during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Michael G. Mason <u>Kimberly Cesky</u> ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kimberly Mason/mother</u>
20a. Method of Disposition <u>506 Hunters Run Drive Bel</u> <u>Air, MD</u> 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify 21. Signature of Funeral Service Licensee Ronald S. W. 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street irector 23a. Pan I. Enter the disense, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval . List only one cause on each line Between Onset and /Medical Death Immediate Conse (Final disease a. Asphyxia Examiner or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day 2 Year past 12 months? Pregnant at time of death 5 Other (Specify) certificate has been signed by the att rector, page 2 should be detached for 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ ER/Outpatient 3 Inpatient 2 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No ۵ 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject found hanging 1 Natural FOUND: 5 Pending 1 Yes 2 V No filled in by the Apr 9, 2012 1256 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be or Town, State) 400 North Haven Street, Baltimore, MD determined (Specify) Woods

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Yea are

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 10, 2012

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mielnik Physician/ 20/2 Maureln 05:57 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death HOWard County General Hospita Columbia Howard 8. Date of Birth (Month, Day, Year) Mar 31, 1953 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign Days Min New York Director 212-74-3219 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location **Funeral Director** MD 1 🗆 Yes 2 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 6334 Cedar Lane UŠA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) N/A Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Carl Mielnik Rita Murphy 19a. Informant's Name/Relationship (Type, Print)
Marylynn Edwards/sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3166 Reash Church Road Cochranton, PA 16314 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 04/28/12 Woodbine, MD 21. Sign of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the unde of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) umonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ور و 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending the Funeral Director: Ai mpleted filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certif 29c. License number 50870 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 13375 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 26, Day 2012 Year 0800 Mabel Emmett Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Himalayan Elder Care Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Dec 31, Yay 1914 Virginia **Director** 223-16-9766 97 1 M 2 XF Usual Residence of Decedent 28a-f show ems 23a or 28a-f shor must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Tes 2 X No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20882 USA 20801 Miracle Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 27 is marked other than "natural", or ite traumatic event, the Medical Examiner Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: White 3 ♥ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mabel Willis West Wade Gordon Emmett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 20801 Miracle Drive Gaithersburg, MD 20882 Henry Martin/son item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Final Journey Crematory 04/28/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lie Coing Holles Chemation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Debility Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical certificate be the 38 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anorexia 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' certificate Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No Other: Assisted ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 XOther (Specify, this Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After Hospital or Attending 1X Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined hours after within 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

101

68760

Box

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 3 0 2012

G. Coleman, M.D. 1355 Piccard Drive Rockville, MD 20850

D37142

April 27, 2012

MULE, ANTHONY

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	Funeral Director		007 40 /000	ex 7. Age 7. Age 8		birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bit (Month, Date 11/08)	ay, Year)	0	irthplace (State or Foreign country) W York
Z Z	a-f show	Director	10a. State 10b. County New York Suffolk	i i	10c. City, To		thport						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
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	ysician/		23a. Part 1. Enter the disease, or common shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	the death. D		er the mode of dy	ng, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. lalor Attending Physician: The law requires that the	been signed b	þ	Part II. Other significant conditions c	ontributing to death bu	t not resultir	ng in the u	nderlying cause o	iven in Part	i.				to the cause of death? Probably 4 💢 Unknown
Recor The law re	certificate has be lirector, page 2 sh	Completed								24a. Was auto perfo 1 \square Yes		prior to death?	utopsy findings available completion of cause of
/ital	certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	+ 2 ∏ EB	(Outpation	-	Place of Dea				☐ Other (Spe	
Division of Vital To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	28a. Date of injury (Month, Day,	28	b. Time of injury	28c. Inju	ry at		28d. Describe			City)
Division Atte	s after death. Il Director: After ed in by the fune		3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.		, farm, stre	eet, factory, office			28f. Location (City or To			ural Route Number,
he Hospit	within 24 hours a To the Funeral I completely filled	Medical	(Check / 2 ☐ Medical Examonly one) / 3 ☐ Certifying Nurs	sician: To the best of n iner: On the basis of ex- se Practitioner: To the	amination an	d/or invest	tigation, in my opin	ion, death o	ccurred at	the time, date	and place	, and due to the	cause(s) and manner stated.
op tot	with	100	29b. Signature and title of certifier	1011			29c. Licen					te signed (Mon	
	15		30. Name and address of person who of PANKIS KHETE	completed cause of de	ath (Item 23:	a) (Type, F	Print) DOO	RUN	Ray	D #+	E, E	360	ms
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			For State	State of Ma	aryland /				d Mental Hy	/giene	001		1.0	0.7	_
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	or 28g	Director	10e. Street and Number	JIE		110	. Zip Code	Lugem	-	10g Citiza	en of What	Count		2 2 2 140	_
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36	after de l', or it kamine	ρ	1 Never Married 2X Married	Armed Forces? 1 Yes 2 1 If Yes, Give	No		specify Cuban, es 212 No		ierto Rican, etc.)	Sr	Black, Wo	hite, etc	c.		
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Mrs. Carolyn M. M				ells Av		Rural Route Numb			2121			ľ
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Baltimore,	t. Page tment tant: jury o		4 Donation 5 Other (Specific)	Hill:	top Se	rvice C	Corp. 5	5/3/2012		son, l				
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	Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	- 0,00	-)							
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Box	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown		5 Othe					Month	D	Day \	Year	
Ö.	at the ed by t detach	F.	Part II. Other significant conditions of	intributing to death bu	it not resulting	in the underly	ing cause give	n in Part I.	23e. Did	tobacco use	contribute	e to the	cause of d	eath?	_
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Ö	ysician: is certifical director,		25. Was case referred to medical examiner?				26. Plac	ce of Death (C	Check only one)						
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Division of Vital Records, P.O. Box 68	Attending Physir death. ctor. After this cottor. After this cottor.	Certificate:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injung (Month, Day,		Time of injury M	28c. Injury a work? 1 \square Y	at ′es 2 □ No	28d, Describe	how injury o	ccurred				
/ISIO	er dea ector by th	ertifi	3 Suicide 6 Could not be 4 Homicide determined		y - At home, fa	ırm, street, fa	ctory, office		28f. Location	Street and N	lumber or I	Rural R	loute Numb	per,	
2	pital or Attencours after deatheral Director.														57
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 2 Medical Exami Certifying Nurs	ician: To the best of n ner: On the basis of ex e Practitioner: To the	amination and/o	or investigation	i, in my opinion	, death occurre	ed at the time, date	and place, at	nd due to th	he cause	e(s) and ma	nner state	d.
	To the virthing complete compl	_ [29b. Signature and title of certifier	`			29c. License r	number		29d. Date	signed (Mo	nth, Da	iy, Year)		
			P Sunden	,			D39	17/8		4	-26	-2	0/8		_
			Schudur 30. Name and address of person who of Weylin Schendel M	ompleted cause of de	ath (Item 23a) ((Type, Print)	ROAD	Suit	e 300,	BAUT	0 ., 1	MI	> 217	237	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) APR 3 0 2012	32. Registrar	's Signature	de					•				

Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	
Division of Vital Records, P.O. Box 68760	o the Hospital or Attending Physician: The law requires that the death certificate be executed if this 24 hours after death. SXAN The law requires that the death certificate be executed by the attending physician and be offered in by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director, and the funeral director is a should be detached for use as the burial-transit by the funeral director.	

	For State		State of	of Marylan		artment of		and M	lental Hy	/giene	е			
	Registrar 1. Decedent's Name	/First Middle I	antl		Cer	tificate of	Death			Reg. N	<u>. 20</u>	12	_13	3/8
ian/ dical		E1i	zabeth	Frances	McCo	rmick			2. Date of De April		ay, 201 ^Y	2ar	3. Time o	
iner	4a. Facility Name (if Suburban			nber)		4b. City, Town,	or Location esda	of Death		40	County of Montg		rv	
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Funeral	11. Marital Status		12. Was Dece	dent Ever in U.S	S. 13. V	Vas Decedent of I Yes, specify Cub	lispanic Or	rigin? (Spe	cify Yes or No-		14. Race -	America	ın Indian,	
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	21. Signature of Fun	1-1	ensee	M0130	5 Ro	Name and Addre bert A. Pu West Mon	ess of Facili	ty Funer	al Home	/Rock	ville.	Inc.	20850-	-2805
	23a. Fart 1 Intel the shoot, or heart Immediate Cause (F	t failure. List only	mplications that c	aused the deatl ch line.							., - <u></u>	1	Approximating	te tween
	disease or condition resulting in death)		_ 8	zure or as a consequ	ence of):							+	Onset and	Dealii
إ	Sequentially list con	nditions.	Asp	iration	Pneum	onitis								
Examiner	if any, leading to imposure. Litter Under Cause (Disease or in	mediate M		or as a consequ pirator		uro								
Exa	that initiated events resulting in death) L		С.	or as a consequ		<u> </u>						+		
edical			d											
I/Me	IF FEMALE: 23b. Was decedent p	pregnant		come of pregna					184		23d. Date of	of deliver		
Pnysician/M	in the past 12 m 1 ☐ Yes 2 X 9 ☐ Unknown	nonths?		nant at time of c		Ectopic pregnan Other (specify)	СУ				Month		,	Year
3	Part II. Other signific Parkinso			eath but not res	ulting in the ur	nderlying cause g	ven in Part	I.	23e. Did t	obacco	use contribu	te to the	cause of d	leath?
3	rarkinso	oll's DIS	ease						1 🗆	Yes 2	X No 3 [Proba	ably 4 🗆	Unknown
Completed			_						24a. Was auto perfo 1 Yes	psv	prio	r to com	sy findings : pletion of c	available cause of
Re	25. Was case referred examiner?		Hospital:				lace of Dea	th (Check		2 620 11	0	7 100 2		
2	1 ∐ Yes 2 X 27. Manner of Death	No	1 X	Inpatient 2 of injury	ER/Outpatient 28b. Time of	DOA Oth	4 ∐ Nı		me 5 Resi			Specify)		
<u> </u>	1 X Natural 2 Accident	5 Pending Investigat	ion	h, Day, Year)	injury	wor		- 1	od. Describe i	now mjur	y occurred			
cei illicate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	28e. Place	of Injury - At ho		et, factory, office		2	28f. Location (S City or Tov			r Rural Fi	Route Numb	per,
Medical	(Check 2 l	Medical Exa	nysician: To the be miner: On the basi urse Practitioner:	s of examination	and/or investi	gation, in my opini	on, death or	ccurred at	the time, date a	and place	e, and due to	the caus	e(s) and ma	anner stated.
	29b. Signature and t			/	20	29c. Licens				29d. Da	te signed (M	lonth, Da	ay, Year)	
	1/2		(5 /	1 14		6264			Apr	i1 25,	201	12	
	30. Name and addres Babak Sal					^{int)} rgetown	Road,	Bet!	hesda,	Mary	y1and	208	L 4	
e	31. Date filed (Month	2012	32. Re	egistra s Signa	arkel									
21	71.11.0			- 11										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per me g927 5-2-12 yt
State of Maryland / Department of Health and Mental Hygiene 20 | 2

item 1 per doc g927 5-16-12 yt
Certificate of Death

Reg. No. For amend item 1 per Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month April 25, Shelia F. McCormack Sheila F. McCormack - Pascasio 11:53 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 16 Red Hearth Court 04/25/201 Baltimore Arbutus . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours **Director** 212-68-9873 1 □ M 2 🔀 F 11/27/56 Maryland 55 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Arbutus 1 Yes 2 No MD ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Somack Funeral USA 21227 16 Red Hearth Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) US Postal Service Letter Carrier Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Belva Gore Lawrence McCormack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a t: If item 27 i Elaine Dailey / Daughter Glen Burnie, Maryland 21061 204 Condon Avenue Sifelia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Department Important: If any injury or once. Loudon Park Cemetery 5/3/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Loudon Park Funeral Rome 22. Name and Address of Facility 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: Interval Between Onset and Death Immediate Cause (Final Ph_sician/ tic Landiovascular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Will Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No ☐ Yes Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 □ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No ours after death.

neral Director: Affiled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) To the Hospital o within 24 hours aft To the Funeral Die Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28,2012 completed cause of death (Item 23a) (Type, Print) ble Hill CT. Lyther Md 2109 Trim onth, Day, Year) Registrar's Signat State 30 Registrar DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month John William Nearhood 7:00 AM M Medical April 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 10729 Park Heights Avenue #C1 Owings Mills Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 220-64-3494 **Director** 1 🕅 M 2 🗆 F 55 May 16, 1956 Maryland Usual Residence of Decedent 10a. State at 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits or 28a-f s notified MD Baltimore Parties Owings Mills 1 Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? be 23a must | 10729 Park Heights Avenue #Cl 21117 USA al Hygiene. d other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 salesperson bookstore Be land and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o ပ Warren David Nearhood Phyllis Levene Powell and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,\,21117$ f Health a item 27 i Patricia Collins/sister 10729 Park Heights Avenue #C1 Owings Mills, MD or other timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Ronald Solvice V censes 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 MD Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CONGESTIVEA Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery the signed by nown able has

P.0. Hospital or Attending Physician: The law requires Division of Vital Records,

Completed To Be

examiner? 1 \subseteq Yes

Manper of Death

Natural

Accident

2 X No

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Month	Day	Year
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to		
		24a. Was an autopsy performed?	death?	utopsy findi completion	of cause
25. Was case referred to medical	26 Place of Poeth /Char				

	3 L Suicide 6 L Could not I			
Sec	4 Homicide determined			(Street and Number or Rural Route Number, own, State)
alcai	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	/sician: To the best of my knowledge, death occurred at the niner: On the basis of examination and/or investigation, in my	e time, date and place, and due to the	cause(s) and manner as stated.
2	only one) 3 Certifying Nu	rse Practitioner: To the best of my knowledge, death occurre	ed at the time, date and place, and due to	the cause(s) and manner as stated.
	29b. Signature and the of certifier	29c L	cense number	20d Date signed (Month Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28a. Date of injury (Month, Day, Year)

5 Pending

Investigation

28c. Injury at

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other Solution 4 House

28d. Describe how injury occurred

ted cause of death (Item 23a) (Type, Print)

State

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 345 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HMORE Social Security Number 6. Sex **Funeral** . Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. **Director** 1 🗶 M 2 🗆 F Usual Residence of Deced 56 9/20/55 Korea within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f s notified 1 Yes 2 No VA <u>Fluvanna</u> Fork Union items 23a or ner must be n 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4238 James Madison Hwy 23055 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, ō Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed A Divorced Specify: Asian Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other trans any injury or other transmatic event at once. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Self Employe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unk Unk 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Americana Drive #204 Annandale VA 22003 <u>Soojin Ock / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atmittery cremetory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crematory 4/16/12 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harman Funeral Service Grayburn Dr Ste G Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial infector, page 2 should be detached for use as the burial-transit completely filled in by the Innerial infector, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 \square No ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an is certificate has director, page 2 s autopsy performed?

Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ၉ 1 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred s after dec. ral Director: Afte 1 Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rumuer

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4b &c Per PHY C926 4/30/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1515 PAK APPLIL 20 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION MENDRIAL HOSEMAL BALTMONE AS WHITES SMIES N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-02-6937 Days Hours 1 🗆 M 2 💢 F Director 87 Oct.20, 1924 Korea Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director Anne Arundel Glen Burnie Maryland 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be Funeral USA 124 South Bridge Drive # 21060 ral", or items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Asian "natural" Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) J Hygiene. J other than " event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker of Health and Mental Hygie If item 27 Is marked other r other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Chong Hwa Chung Unknown Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau Wan K. Pak - Son 1124 Cedarcliff Drive, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem Park 04/24/2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of Fur eral Service Lio 7250 Washington Blvd., Elkridge, Maryland 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) ISUAFMIC BOWEL Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of): -transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Penneral Director. After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year n signed by the a 2 No 1 ☐ Yes ∠ y g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by SHOUK Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ➡ Jnknown page 2 should MUST ONLAW FAILURE (RESPIRATIONY, CIRCULATIONY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No RENAL) HEPATO BILLARY. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **N** No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 ANatural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, detail occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number AT-2438946-D35 APRIL 20 2012 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple

DHMH 17 Rev 06-2011

State Registrar 777 S. EDEN St.

854 JAN

BAUTIMORE MD 21231

DEFOR

32. Registrar

KENHEM

		,	For State Registrar	State of M	arylan	-		lealth a	nd Mental Hy		0 2	13384
	Physicia	n/	1. Decedent's Name (First, Middle, L		_				2. Date of De	aath	Year	3. Time of Death
Medi		cal	JAMES G. 4a. Facility Name (if not institution, gi	ARVEL	11					Day 27	12	1145 PM
-	Examir	ıer	MERCY MEDICAL	(ENTER			4b. City, Town, or	-TIMO		4c. Coun	ty of Death	
	Funeral Director		5. Social Sequrity Number 6. 220–62–0823 Usual Residence of Decedent		5 9	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Date of Bit		9. Birthpl Counti	ace (State or Foreign Ty) MD
	and show	٥	10a. State 10b. County		10c. City	y, Town or Lo	cation				10	Od. Inside City Limits
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	ith the		10e. Street and Number				10f. Zip Code		-	10g. Citizen o	f What Count	ry?
	ems 2	Funeral	2302 Beren Lane 11. Marital Status	12. Was Decedent E	Ever in U.S	S. 13. V	21157	spanic Origin	n? (Specify Yes or No-	United		
9600	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Nidowed 4 Divorced	Armed Forces?			Yes, specify Cubal		n? (Specify Yes or No- Puerto Rican, etc.)	Specif	ace - America ack, White, et fy: Whi	tc.
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mo	Page nent o ant: If ury or		■ Burial 2 Cremation 3 Donation 5 Other (Spec		C	emetery, crem	atory or other place	´ !	5/1/2012		•	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot once.	Į,	21. Signature of Fineral Sovice Le	Ellen		Bu 12	Name and Addres	s of Facility en Fu	neral Home rty Rd. Wi	and Cr	emato	ry, P.A.
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3876	rtificat ling ph e as th	/Mec	IF FEMALE:	20 11								
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at g Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				ate of deliver onth D	y Day Year
P.0	requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the ur	iderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to the	cause of death?
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<u>a</u>	an: Th tificate tor, pa		25. Was case referred to medical		-		26. Pla	ce of Death	1 ☐ Yes (Check only one)	2 🗷 No	1 Yes 2	X No
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	₽ ₹ ₽ 8		29b. Signature and title of certifier				29c. License	number 307		29d. Date signe		y, Year)
		-	30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type, Pr		J. T		11/2/1/2	2012-	
	1		DAVID A. VITBERL	MD 345	54.	PAUL P	LACE B	ALTIM	ORE, MD	21201		
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			For	State of Ma	ryland / Depa			id Mental Hy	giene	012	10	205
			State Registrar		Cer	tificate of L	Death			13.	385	
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סר ַ	<u> </u>		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	20b. Place of Dispos cemetery, crem	ition (Name of atory or other plac	e)	Date	20c. Location	- City or To	wn, State	
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IVISION	after de Directo	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stree Specify)	et, factory, office	A.F	28f. Location (S City or Tow	treet and Numb n, State)	er or Rural i	Route Number,	r i
J Efficient	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	cian: To the best of my	/ knowledge, death or	ccurred at the time	, date and place	ce, and due to the ca	use(s) and man	ner as state	d.	acretated
tha t	thin 24		only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the b	est of my knowledge, o	death occurred at th	ne time, date ar	nd place, and due to t	ne cause(s) and r	manner as st	ated.	
1	§ ≥ 6 8		Maney D. Li	King		D004	40904		29d. Date signe	2.1	2012	
		}	30. Name and address of person who cor	mpleted cause of deat	יין יע). th (Item 23a) (Type, Pri	nt)	, - ,		· · · · · ·	-)		
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	Stat Registra	e	31. Date filed (Month, Day, Year) APR 3 0 2012	62. Registrar's	M.D. th (Item 23a) (Type, Pri Marda (Signature	ane, this	apolis	s , mary a	na out	03-1	100	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ 1 roll Medical Facility Name (if not institution, give street and Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE BATIMORE BATIMORE If Under 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Age (In vrs. last birthday 9. Birthplace (State or Foreign 216-20-5454 Country) Director 1 - M 2 XF Yrs 11-15-1924 Usual Residence of Deceden 10a. State 10d. Inside City Limits 10c. City, Town or Location Director notified 28a-f MD BALTIMORE 1 Yes 2 □ No 10e. Street and Number or 10g. Citizen of What Country? must be 23a Funeral NORTH BOND 21213 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iten Examiner Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔊 No Specify Specify: BLACK "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) the 2 HOUSENIFE DOMESTIC Be Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ ALS TON MARY ESTER BOY D 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num 6804 SOUTHERN C ROSS COURT, GWYNN DAK, MO. 21207 KOYSTER DTR-IN-LAW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 Department of I-Important: If ite any injury or oth Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 DAHIMORE, MD permit. Signature of Funeral Service Licenter VAUGHN GREENE FUNERAL SCUS Z use, or comb cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre List only one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Lis Approximate terval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Line to for as a consequence or; burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atter should be detached for u in the past 12 months? Year Month Day Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending iniury Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To HED est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day,

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State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No. 2

441 AM

10d. Inside City Limits

white

1 ☐ Yes 2√ No

unk

Approximate Interval Between Onset and Death

Day

Year

Physician /Medical Examiner

Director

Funeral

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Certification: To

Medical

Funeral Director

the Maryland 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evant or must be notified at death with filed within 72 hours after 2 should be fi and Mental F Health a item 27 other t Pages 1 Department of Important: If it any Injury or conce.

Menc

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, P.O. s been signed by the should be detached Division of Vital Records, page 2 s certificate has funeral director, After this or Attending death within 24 hours after death

To the Funeral Director:
completely filled in by the

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Raymond Lester Richardson 20 2012 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore FRANKLin Square HOSPITal Rosedale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F 244-26-0878 86 5, 1925 Nov North Carolina Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Kerria Lane 21220 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3₺ Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk roofer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Barton/friend Kerria Lane Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state Signature of Funeral Serv 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Lise (Final Pheumonia ASPIRATION disease or condition resulting in death) Due to (or as a consequence of): Respitory Failu Sequentially list conditions, it is a list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.D Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes_ 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 1 Natural

(Check only one)

5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide

4 ☐ Homicide 29a, Certifier

determined

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

29b. Signature and title of certifier

D73048

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

20112

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIY SQUARE DR Balto Md 21237 DR muhannad Kanbour

State Registrar

31. Date filed (Month, Day, Year) APR 3 0 2012 32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 13388 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sandra Lee Roy 0247 A.M 2012 April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice-Dove House Westminster Carroll Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) (Month, Day, Year) (Ant. 14,1960 Hours 216-84-0353 Sept. 51 1 M 2 X F Maryland Usual Residence of Decede 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland Carroll Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7385 Gaither Road 21784 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2XX Married 1 Yes 2XXNo 1 Yes 2XXNo Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Claims Adjuster US F & G Ins. 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Grover Junior Conwell Susie Lee Newsome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Roy Husband 7385 Gaither Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Meadow Branch Cemetery 4/30/2012 Westminster, MD ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Burrier-Oueen Crematory, Funeral Home & Cremat iberty Road Winfield 1212 W. Old Liberty Road

there the mode of dying, such as cardiac or respiratory arrest, Part/1. Enter the disease, or complications that caused the death. Do not enter spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year

Physicani) Medical Examiner

death certificate be P.O. Box 68760

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Division of Vital

Hospital or Attending Physician: The law

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24 hours after death. Funeral Director: After

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Physician/

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10a. State

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Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic and injury or other traumatic and

within 72 hours after

3altimore, Maryland 21215-0036

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Medical Examiner

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burial-trai attending physician for use as the buria Physician/Medical hed signed by d be detac page 2 Certificate: filled in by the Medical

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregpant in the past 12 months?
1 ☐ Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 1 Yes 25. Was case referred to dical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

29a. Certifiei only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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		•	For State Registrar		State of Ma	aryianu	Cer	tificate	of D	eaith eath	IIU IV	lentai riy	Reg. No	-	12	13	389
	Physicia	n/	1. Decedent's Name						2. Date of De Month April	24 ^{Dar}	y 201	Year	3. Time of 2115	Death M			
	Medic Examin								4b. City, Town, or Location of Death					1 24 2012 211			IVI
	£		Gilchris		Colu	mbi	a			Howard							
6	Funeral		5. Social Security Nur			e (In yrs. last	birthday)	If Under 1 Year If Under 24 Hrs			4 Hrs. Min.	8. Date of Bir (Month, Da			9. Birthp Count	lace (State or	Foreign
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	and show	tor	10a. State	10b. County		10c. City, To	own or Loc	ation							10	0d. Inside Cit	y Limits
	Mary 28a-f otifie	Director	MD	Frederic	:k	Mt. A	Airy									1 🗌 Yes	2 X No
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	ath wi	Funeral	14054 Hai	rrisville	12. Was Decedent E	ver in ILS	13 W	/as Deceder	217		n? (Sne	cify Yes or No-	Т	USA 14. Race	A i	- Indian	
J036	within 72 hours after death with the Maryland jiene. 9r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	1 Never Marrie		Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Yes, specify Yes 2			Puerto F	cify Yes or No- Rican, etc.)			White, e	etc.	
215-0036	within 72 hou giene. ier than "na ti ier the Medic a	Completed	(Speci	15. Decedent's Ed ify only highest grad dary (0-12)	de completed) College (1-4 or 5		(Give k life. DC	ent's Usual (ind of work) NOT use re	done du	tion ring most o	of workir	g	Emp	ind of Busi loyme ruite	ent	lustry	
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galtimore,	ge 1 and it of Healt If item 2		20a. Method of Dispo 1 ☐ Burial 2X		Removal from State	20b. Place ceme	e of Dispos etery, crem	sition (Name atory or oth	e of er place,)		ate	20c. Lc	ocation - C	ity or To	wn, State	
	permit. Page 1 a Department of H Important: If ite any injury or ot		4 Donation 5	5 Other (Specify)	Final						27/12		dbine			_
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	Medical Examiner		resulting in death)	•	Due to (or as a	consequenc		N. N. Jan. J. M. J.			30.2					1	
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000	ertifica Iding p	/Me	IF FEMALE: 23b. Was decedent pi	rognant	3c. If yes, outcome of	of pregnancy								22d Data	of delive	N7. (
. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 mg 1 Yes 2 Unknown	onths?	1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pre Other (spec			_			23d. Date Monti			ear
S, F.O	ires that t signed b Id be deta	by	Part II. Other signific	ant conditions co	ntributing to death bu	ut not resultir	ng in the ur	derlying ca	use give	n in Part I.						e cause of de	
Vital Records,	w requ	Completed										24a. Was		24b. We	ere autop	sy findings a	vailable
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<u> </u>	sian: 7	Be C	25. Was case referred examiner?	L.					26. Plac	e of Death	(Check		2 40 110	7			
=	Physic this co	ရ	1 🗆 Yes 2 🕏	No F	lospital: 1 Inpatie 28a. Date of injur	ent 2 ER				4 ∐ Nurs	$\overline{}$	ne 5 🗌 Resid				Hosp	ice
DIVISION OF	tending fleath. tor: After the funer	Certificate:	2 Accident	5 Pending Investigation 6 Could not be	(Month, Day,	Year)	28b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No					28d. Describe how injury occurred					
DIVIS	ital or At urs after o ral Direct		3 Suicide 4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)										tion (Street and Number or Rural Route Number, or Town, State)				
	the Hosp iin 24 hou the Fune ipletely fi	Medical	(Check 2 L	Medical Examin	er: On the basis of ex	amination an	d/or investi	occurred at the time, date and place, and due to the stigation, in my opinion, death occurred at the time, date and place, and due to					and place, and due to the cause(s) and manner stated.				
_	Nith To 1		29b. Signature and titl	le of certifier					icense r				29d. Dat	e signed (/		lay, Year)	
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	Stat		31. Date filed (Month,		62. Registra	r's Signature	hora	2	- ,			- 1 - 2 (-)	- 1/		100	+	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>12</u> Physician/ 6:20 Рм April 25 Edward Stephen Ring, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise of Rockville Rockville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🗓 M 2 🗆 F 357-18-4113 December 31, 1926 I owa 85 Yrs. **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 X Yes 2 □ No Maryland Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a must be Funeral 20850 United States 8 Baltimore Road 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Black, White, etc. WWII 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Executive Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward Stephen Ring, Sr. Ann McGinnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Main Street, #215, Gaithersburg, Maryland 20878 Stephen H. Ring / Son other Important: If iten any injury or othe once. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Hampstead, May 4, 2012 Sea Lawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) North_Carolina 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Inflette Dup 12 M01305 23a. Part 11 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 2 Owet and Beath Dysphagia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Advanced Dementia Years Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? performed? this certificate Yes 2 No I or Attending Physician: after death.
Director: After this certific 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Assisted
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) Living Hospital: 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the within 2

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Registrar

14816 Physicians Lane, Suite 152, Rockville, Maryland 20850 Sharma R. Mittal, M.D. 32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

ama

29c. License number

D0061382

29d. Date signed (Month, Day, Year)

April 26, 2012

			For	State of	Marylar	nd / Depa	artment of H	lealth and	Mental Hyo	giene					
			1 - State Registrar Certificate of Death Reg. No. 2									<u> </u>			
	Physicia	in/	1. Decedent's Name (First, Middle,	,				Date of Dea Month	th Day	3. Time of Death					
-	Medic		Glenna Alvert 4a. Facility Name (if not institution, s						<u> April</u>	April 22 2012 9:1:					
	Examir	ner				-	4b. City, Town, or		ith	4c. County					
	Funeral		1765 Keysville 5. Social Security Number		Apt. Age (In yrs. i		Keymar If Under 1 Year	If Under 24 Hr	s. 8, Date of Birth	Carr		ace (State or Foreign			
ì.	Director		220-26-0500	1 □ M 2 X] F	81	Yrs.	Months Days	Hours Mir			Mary				
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	urylan a-f sh ïed a	Director	,		10c. Cit	ty, Town or Loc	cation				10	d. Inside City Limits			
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	tems er mu	Funeral	1765 Keysville R	12. Was Deced	ent Ever in U.	S. 13. V	Vas Decedent of His	spanic Origin? (8	Specify Yes or No-	USA 14 Bace	e - America	n Indian			
98	ifter d ", or i	2	1 Never Married 2 XMarrie	Armed Force 1 Yes 2 If Yes, Give	2 💢 No		Yes, specify Cubar		to Rican, etc.)	Blac	k, White, et	c.			
Ö	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed	3 Widowed 4 Divorced	Year or Date			Yes 2 X No			Specify:	Whit	e			
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yla	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	임	Glenn M. Stamba	uah				Margar	et Lescal	leet					
Mar	should and Me	9	19a. Informant's Name/Relationship			1			ural Route Number,			•			
e,	and 2 s Health tem 27		Harless M. Reid/ 20a. Method of Disposition	husband	1001. 5			e Rd So	uth Apt.D						
Baltimore, Maryland 21215-0036	permit. Page 1 and in Department of Heall Important: If item 2 any injury or other once.		1 Burial 2 Tremation 3	Removal from S	tate c	emetery, crem	sition (Name of atory or other place	· !	Date	20c. Location -	•				
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that car	used the deat	h. Do not enter	r the mode of dying	, such as cardia	c or respiratory arre	st,		Approximate			
- J	hysician/	5 9	Immediate Cause (Final disease or condition		CARD	iAL	INFAR	CTION	1			nterval Between Onset and Death			
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		er	Sequentially list conditions	b. —											
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876	tificat ng ph	Med	IF FEMALE:			_									
9 X	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	th 2 🗌 Feta	Ideath 3	Ectopic pregnancy				of delivery				
ĕ	e dea the a	ysic	1 Yes 2 No	4 ☐ Pregna 9 ☐ Unknov	nt at time of d wn	leath 5 🗌	Other (specify)			Mon	th D	ay Year			
Division of Vital Records, P.O. Box 687	requires that the death certific been signed by the attending I should be detached for use as	by Physician/M	Part II. Other significant conditions	contributing to dea	th but not resi	ulting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contril	oute to the	cause of death?			
S,	uires t n sign uld be	q pa	HYPER TENS	LON					1 🗆 Ye	es 2 🗆 No	3 🗌 Proba	oly 4 Donknown			
Ö	w red is bee 2 sho	plet	HYPER LIPID	EMIA					24a. Was ar	24b, W	ere autops	re autopsy findings available			
Rec	ysician: The law is certificate has to director, page 2 s	Completed	PAROXYSMAL	ATRIA	LI	= IBRIL	LATION		autops perform	ned? de	rior to completion of cause of eath? Yes 2 No				
ta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?					ce of Death (Che		140	103 2				
Ž	Physic this c	유	1 Yes 2 No 27, Manner of Death			ER/Outpatient		4 L Nursing I	lome 5 Reside	nce 6 Other	(Specify)				
n o	d ing ding h. After funer	Certificate:	1 Natural 5 ☐ Pending		Day, Year)	28b, Time of injury	28c. Injury : work?	at es 2 🗌 No	28d. Describe ho	w injury occurred	i				
SIO	Atten r deat ctor:	ij.	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be	Injury - At hor	me, farm, stree	M 1 ☐ Y	es 2 LINO	28f. Location (Str	net and Number	or Pumi P	auto Alumba v			
<u> </u>	s afte		4 - Normicide determine	building,	etc. (Specify))	,, ,		City or Town,		or nurar n	oute Number,			
	The Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death certificate has been signed by the attending the Funeral Director. After this certificate has been signed by the attending mpletely filled in by the funeral director, page 2 should be detached for use as	edical	29a, Certifier 1 Certifying Pl	hysician: To the besi	t of my knowle	edge, death oc	curred at the time,	date and place,	and due to the cau	se(s) and manne	r as stated.				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Σ∣	only one) 3 - Certifying N	urse Practitioner: To	the best of m	iy knowledge, d	leath occurred at the	time, date and p	at the time, date and place, and due to the	place, and due to cause(s) and ma	nner as sta	(s) and manner stated, ed.			
	2 × 2 8		29b. Signature and title of certifier		7	M. D.	29c. License r	- 1		Od. Date signed					
		ł	30. Name and address of person wh	n completed source	of death /lac-	23a) /Time D	01) 1:17	5458	LTIMORE	07/3	5/20	019			
			WASIM FA	KHAR,	M - D	= (Type, Pri	1 ' /	E SA EYTOWN	LTIMORE I. M.D	STRE	ピてコ	# "			
	State	~	31. Date filed (Month, Day, Year)		strar's Signat	1. par		- (/ 0 4 /	, , c 22	×1 13	7				
	Registra	r	yek a a ca	IL CEN	m p	gar									

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

900 CATON

AVE BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Betty Gathings Snyder 2012 4:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3160 Gracefield Road #3342 Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🖼 F Hours Carolina South Apr 22, 1924 Director 87 251-16-8325 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Prince George's Silver Spring 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road #3342 20904 USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed Specify: White 3 X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည James G. Gathings Minnie Belle Smith 19a. Informant's Name/Relationship (Type, Print) fitem 27 is n other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Madeline Road Ridge, NY 11961 Diana Zuchelli/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 4/27/12 Woodbine, MD 21. Signature of Funeral Service Licensee Goinganomes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cerebral Vascular Accident week Medical resulting in death) Examiner <u>Hypertension</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IE EEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Pregnant at time of death Day 2 X No g Unknown cate has been signed by the page 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascular Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No Yes 2X No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital the funeral director. Be 26. Place of Death (Check only one) Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 5 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, MD 20904 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year Richard Farrow Sears, Sr. April 21, 10:18 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7904 Chelton Road Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Days Hours 069-30-5750 **Director** 74 1 🛛 M 2 🗆 F Feb. 21, 1938 New York 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Maryland Bethesda Montgomery 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20814 7904 Chelton Road United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ite 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Specify. **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than ' United States College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Executive Officer Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Washington Sears, Sr. Margaret O'Keath Alston and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Health attem 27 Jason C. Sears/Son 7231 Boyer St., Philadelphia, Pennsylvania 19119 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State April 27, 1 Burial 2 X Cremation 3 Removal from State Montgomery crematory or other place) Bethesda, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, 21. Signatur of Fundal Sovice Licensee R2 Name and Address of Facility ROBert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
years Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease 13 years if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Diabetes Mellitus Type II 25 years the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the at d be detached for 2 No 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Anemia Secondary to Chronic Kidney Disease Were autopsy findings available prior to completion of cause of 24a. Was an certificate has performed? death? Yes 2 🗓 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 X Yes 2 □ No ᅌ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Hospital or Attending 24 hours after death. 2 Accident
3 Suis 1 X Natural 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ames I Marken MD D37678 April 23, 2012

State Registrar

31. Date filed (Month, Day, Year)

James F. Mackin, M.D. 5454 Wisconsin Ave., #675, Chevy Chase, Maryland 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROBERT 2012 SILBERG APRIL 4:28A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Director 218-07-1520 1 🛛 M 2 🗆 F 89 05/19/1922 Usual Residence of Decedent MD 28a-f show at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No MD BALTIMORE PIKESVILLE -10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 725 MT WILSON LANE, 21208 death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?
1 ☑ Yes 2 ☐ No 0 Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 SALES WORLD BOOK ENCYCLOPEDIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ABE SILBERG LENA SILVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau EVELYN SILBERG/WIFE 725 MT. WILSON LANE, #125, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ARLINGTON CEMETERY
CHIZUK AMUNO CONG 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2012 BALTIMORE, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Providiciae/ YPav disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed? Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death. I **Director:** After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🔲 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours after To the Funeral Direc Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier April 25,2012 30. Name and address of person who co use of death (Item 23a) (Type Print) 717204 ZIBELL MD Smith Jef 2835 Ave

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G926 4/30/2012 III of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 Franklin William Taylor 6:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 7392 Back Street Newcomb Talbot Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Min. **Director** 465-12-8559 1 🛛 M 2 🗆 F 86 11/24/1925 Louisiana iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 X Yes 2 No MD Talbot Newcomb 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7392 Back Street 21653 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Sales Publications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Theodore Taylor Angel Barbie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Carter / Wife P.O. Box 185, Newcomb, MD 21653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 D Other (Specify) Hanover, Maryland Anatomy Gifts Registry 04/18/2012 21. Signature of Juneral Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Pulminan Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner morin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No jo Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Ves $2 \square$ No $3 \square$ Probably $4 \square$ Unknown Hypercholesterolemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 □ Nursing Home 5 XXResidence 6 BOther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29d. Date signed (Month, Day, Year, Mussell a. Erlenen or 04-16-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A Schilling DO 555 Cynwood Br Easton, m & 21401 31. Date filed (Month, Day, Year) APR 3 0 2012 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Robert Lee Trobaugh, Jr. 2012 21 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Days Hours 334-46-1724 **Director** 1 X M 2 □ F 58 December 15, 1953 Illinois Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Bethesda 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6405 Lone Oak Drive 20817 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. ō þ Yes, Give 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Tes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Satellite other than Elementary/Secondary (0-12) College (1-4 or 5+) Communications Electronic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ Robert Lee Trobaugh Mildred Mallman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Teresa M. Trobaugh / Wife 6405 Lone Oak Drive, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date - i - i 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State cemetery, crematory or other place, April 2012 Department of Important: If any injury or Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Signature of Funeral Service Licensee M01305 Robert A. Pumphrey Funeral Home, R 300 West Montgomery Avenue, Rockvi 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Hepatic Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Pregnant at time of death in the past 12 months? Day Year signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 X No certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No Other: မ 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 🔄 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending iniury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar

31. Date filed (Month, Day, Year) APR 3 0 2012

29b. Signature

8600 Old Georgetown Road, Bethesda, Maryland 20814 Atul Rohatgi, MD 32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DAVID VANCE 00 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE FREY MEDICA ENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** 1**XX**M 2 □ F Days Hours Min. 37 216-84-5301 Yrs 03/26/1975 Director Usual Residence of Decedent 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 252 South Dallas Ct. 21231 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces? Black, White, etc ģ 1 XXNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Black Specify. Completed 3 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with th and Mental Hygien 7 is marked other t Janitorial Maintenance Custodial Service 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daryl Batten Phyllis Vance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or with Phyllis Sichette / Mother 252 South Dallas Ct., Baltimore, MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
W. Arundel Crematory 1 \square Buria! 2 X Cremation 3 \square Removal from State 05/01/2012 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Services, PA M01452 4023 Annapolis Rd., Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ LEJMOCYCTIS disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed? death? this certificate 1 🗌 Yes 2 🕱 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 1 X Natural 5 \square Pending n 24 hours after death.

The Funeral Director: All oldered filled in by the funeral controls. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) . 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 164307 (iM 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar GIVAG

A .

31. Date filed (Month, Day, Year)

VITBERL

MD

32. Registrar's Sig

PAUL

PLACE

BALTIMORE

21201

MD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	ineral Service I	icensee . Walte	Vir	ector	~ 22 S B	Name and Addre tate Ana altimore	ss of Fac tomy MD	Boar 212	d 655 V	J. B	altim	ore	Stre	et
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Medical Examiner		resulting in death)		(a	oue to (or as	a consequ	ence of):		. 110	, ,					100	P-4
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 (Check 2	Certifying	Physician: To	the best of	f my knowle	edge, death o	h occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year Donald Thomas Weiss AM^M Medical April 10:10 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Numbe Year If Under 24 Hrs. Days Hours Min. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 220-30-2536 1 🕅 M 2 □ F 77 Feb 9, 1935 Maryland 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 1406 Joppa Forest Drive 21085 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) unk marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 4 salesperson injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked of George Weiss Alice Miskimon 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Weiss/spouse 1406 Joppa Forest Drive Joppa, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) Scen ²State Anatomy Board 655 W. Baltimore Street w MD Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CEREBROVASCULAR ACCIDENT Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform Yes 2 X No the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 👿 No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature a 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

JACKIE JONES,

APR 3 0 2012

31. Date filed (Month, Day, Year)

TIMONIUM,

MD 21093

2300 DULANEY VALLEY RD.

Dur A. fall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Williams JRI Month Physician/ Ernest 2:00A M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Randallstown Baltimore Seasons Hospice/Northwest Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 243-46-4746 Director 1**X** M 2 □ F 75 Jan.6,1937 N.Carolina Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 4403 Silver Brook Lane Apt.A101 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or iter Medical Examiner Armed Forces' Black, White, etc 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. New York Transit Elementary/Secondary (0-12) College (1-4 or 5+) the Operator Authority years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Williams Sr. Delia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 2 1 1 1 7 Department of Health ar Important: If item 27 is any injury or other traumonce. Rita Williams/wife 4403 Silver Brook Lane Apt.A101 Owings Mills 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 05/01/12 Owings Mills, Md. Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore,Md.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiorascular Disease Physician/ Atheroscierotic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (cros a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Month Year signed by the at Id be detached for Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Trinknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? Il or Attending Physician: The after death.

Director: After this certificate h 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other Specify Novpice 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MSRAJAPANIMO 00057465

State Registrar 31. Date filed (Month, Day, Year)

YV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NS Raj GAN SEMD 2835 Smith Av 5203 Bathmare MD Z1209

Baltimore, Maryland 21215-0036 APRIL 24, 2012 10:45 a.m. Division of Vital Records, P.O. Box 68760 Cg. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. TERRY WALTERS

	1 - For State Registra	r	State of	iviaryian		artmer rtificat			and N	/lental Hy	gien Reg. N	20	112	134	02
ician/ edical	Te	rry Lou W	,	1						2. Date of De Month April	24			3. Time of Dea 10:45	
miner	Stell	a Maris	give street and number	er)		4b. City, Town, or Location of Death Timonium					Balt:	of Death imore			
ral tor	5. Social Sector 215-60	,	6. Sex 7.	. Age (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year,		Count	,,	
اة	Usual Resid	ence of Decedent 10b. County		10c. City	, Town or Lo	ocation				01/06/	193	00		Virginia Od. Inside City Li	
To Be Completed by Funeral Director	Maryla 10e. Street ar		ord	J	орра	10f. Zir	0-1-							1 🗆 Yes 2	X No
Funeral Director		Emmerick 1	Drive			101. 24	2108	85				S.A.	What Coun	try?	
ed by Fu		atus r Married 2 X️Marr wed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? No		Was Deced If Yes, spec 1 Yes	ify Cubar	spanic Ori , Mexical Specify	n, Puerto	ecify Yes or No- Rican, etc.)		Blac	e - America k, White, e Whit	etc.	
Completed						dent's Usua kind of woo DO NOT use nemake	rk done di retired)		st of worki	ing		Kind of Bu		ss/Industry	
To Be	17. Father's N	ame (First, Middle, Li il Hull	ast)		11011	il Cinara				e (First, Middle, Smith					
	Jeffr	nt's Name/Relationsh ey D. Wal								oppa, M					_ 1
			3 ☐ Removal from St	tate . ce	ace of Dispo emetery, cre ent Cr	matory or o	ther place)		5/20 1 2			City or Tov	wn, State ryland	
	> m		reulli-		16	5009 F	larfo	rd R	oad .	zullo F Baltimo	re,	ral (Mary	Chape /land	1, P.A. 21214	
dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):														
Physician/Med	in the pa 1 ☐ Yes	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □						☐ Ectopic pregnancy ☐ Other (specify)					e of deliver	ry Day Year	
ρ	Part II. Other	significant condition	ns contributing to deat	th but not resu	llting in the u	underlying o	ause give	en in Part	1.	1.			ibute to the	e cause of death	
Completed										24a, Was autor perfo 1 Yes	osy orm <u>ed</u> ?	l c	Vere autoportion to compleath?	sy findings availant pletion of cause	able e of
To Be	examiner?	referred to medical	Hospital:	patient 2 \square F	-B/Outpatie	26, Place of Death (Check only one) tient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) HOSPICE						,			
Certificate: 1	1 X Natu 2 Accid	27. Manner of Death 1					nt 3 L DOA 4 Nursing Home 5 L Residence 6							HUSFICE	·
		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)										tion (Street and Number or Rural Route Number, or Town, State)			
Medical	29a. Certifier (Check only one	2 Medical Ex	Physician: To the best caminer: On the basis of Nurse Practitioner: To	of examination	and/or inves	tigation, in r	ny opinion irred at the	, death oo e time, da	ccurred at	the time, date a	ind plac he caus	e, and due se(s) and m	to the caus anner as st	se(s) and manner ated.	stated.
	29b. Signature	and tiple of certifier	SAM	,		290	License I	number	2		29d. D.	ate signed	(Month, Di	ay, Year)	
	JACK]	E JONES,	tho completed cause of CRNP 2300	of death (Item 2			RD.	TIMO	NIUM	, MD 21	.093		1		
ate trar		Month, Day, Year)		trar's Signatu											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Arthur D. Wrightstone Day 2012 P^{M} Medical April :29 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Co. Towson Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Davs Hours Min. **Director** 1 🖾 M 2 🗆 F 167-14-4008 30,1919 PA Nov. 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3424 Yardley Drive 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Give White Completed 3 Widowed 4 Divorced Specify. WWII Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Years Master Sergeant Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Wrightstone Iva Detweiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Deborah K. Podles (Daughter) 1726 Beechwood Ave. Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Gdns. of Faith Cem. 4 Donation 5 Other (Specify) 4/27/2012 Baltimore, Maryland 21. Signatur uneral Service Licensee Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MICH Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 2 No Yes 1 🗌 Yes 25. Was case referred to medica examiner? Be Division of Vital 26. Place of Death (Check only one) Hospital 2 No Other: 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tes 2 🗌 No Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 24 2012 ss of person who completed cause of death (Item 23a) (Type, Print) CHANGES Chases W Tow son 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 30 Registrar

ORIGINAL

amend 28b, per me, g928 6-15-12 sm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2

1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2012 5:00A Weller Doris Frances Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Frederick Kline Hospice House Mt. Airy 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **Director** 214-76-9928 1 | M 2 | X F 97 Mar. 7, 1915 Yrs Maryland Usual Residence of Dece 10d. Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Examiner must be notified 1 Yes 2 X No Monrovia Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Funeral 23a U.S.A. 11514 Weller Rd. 21770 'natural", or items and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11 Marital Status Black, White, etc. by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker 5 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ပ Mary Etta Remick Luther Caleb McDonough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monrovia, MD 21770 Doris Hamilton/daughter 4502 Green Valley Rd. injury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or oth cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4/28/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 22. Name and Address of Facility Hartzler Funeral Home, P.A. of Faneral Service Licensee rati Libertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 610 010 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 9 Sequentially list conditions Examiner Due to (ur asja conseque if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 0 Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death g ☐ Unknown g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 After this certificate has ours after death.

eral Director: After this certific: filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) hospice 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury unk the Hospital or Attending work?
1 Yes 2 No Natural 5 Pending 5:00/M 4/1 2 Accident 3 Suicide Investigation 6 Could not be lace Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Home 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main St. Date filed (Month, Day, Year) State APR 3 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 13405 1- For State Certificate of Death Rea No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day April 27, 2012 1730 hrs **Medical Examiner** Margaret Ann Williams 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Agnes Hospital **Baltimore** If Under 24Hrs. 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Min. Hours Director 2 X F Count Maryland M Yrs 11/07/1929 214-26-7952 Usual Residence of Decedent in, 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No limore, MD 21215-0036

. Pages I and 2 should be filed within 72 hours after death with the Maryland innent of Heath and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f ahov or other traumatic event, the Medical Examiner must be notified at once. MD Baltimore Catonsville Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? **USA** 21228 717 Maiden Choice Lane Apt. 616 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: White 2 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller Bank 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Caroline Hefner Raymond S. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Oak Lodge Rd. Catonsville, Maryland 21228 <u>Laurel Lee Williams / Daughter</u> 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Itimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/1/12 Baltimore, Maryland Loudon Park Cemetery 4 Donation 5 Other Specify: 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funera Home 3620 Wilkens Ave. Baltimore, maryland 21229 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. Lift only one cause Between Onset and each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical the attending physician a ned for use as the burial -AMENDED 23a, pt.II, 27, 28a-f, per me, g928 6-22-12 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FFMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 V Unknown Osteoporosis: Atherosclerotic Cardiovascular Disease Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be Hospital: 1 ___ Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 1 Yes No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural Director: 5 Pending 1 Yes 2 X No unknown hours after death. fd 4-27-12 | fd 10:00 am Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 711 Malden Choice Ln. Catonsville, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide Found:nursing Home determined (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 28, 2012 Miles zoli 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Dans 31. Date filed (Month, Day, Year) State Registrar's Signature arked Registrar

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ STEPHEN HENRY WINER 2012 12:49 Medical APRIT 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL TOWSON CENTER 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Hours Director 213-48-4277 1 X M 2 □ F 66 12/12/1945 Usual Residence of Decede MD 28a-f show 10a. State 10b Count at 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD 1 Yes 2XX No BALTIMORE COCKEYSVILLE 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 300 INTERNATIONAL CIRCLE 21030 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or q 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 XWidowed 4 Divorced Specify Completed Year or Dates WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Important If item 27 is marked other than any injury or other traumatic event once. SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4 or 5+) UNKNOWN ADMINISTRATION Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ WALTER WINER **JEAN** FOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER PAUL/PERSONAL REP 300 INTERNATIONAL CIRCLE, COCKEYSVILLE, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 \square Cremation 3 \square Removal from State cemetery crematory or other place KNESSETH ISRAEL 04/27/2012 4 Donation 5 Other (Specify) BALTIMORE, MD KOLK CEM 21. Signature of Funeral Seven Lice and 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No q Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed? Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) funeral of 27. Manner Ceath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation M Director 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check

29b. Signature and title of certifier

30

ompleted cause of death (Item 23a) (Type, Print)

35

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

25

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ April 27, 6:40 Рм Cornelia C. Wilkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 218-14-1461 Director 1 M 2 XF 6/24/23 Maryland 88 Usual Residence of Deced r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Catonsville Baltimore 1 Tes 2 No Md 10e. Street and Number 10f. Zip Code 5 ms 23a or must be r 10g. Citizen of What Country? Funeral 21228 USA 719 Maiden Choice Lane BR119 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner or. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George W. Wellham Jr. Ida Virginia Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 soft Health in tem 27 in other tra George A. Brown / Son-in-Law Bowen Mill Rd. Baltimore, Maryland 21212 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State <u>o</u> = 0 Page 1 1 🗆 Burial 2 🗷 Cremation 3 🗀 Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 4/30/12 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home . Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Ischemic Medical Due to (or as a consequence of): Examiner 865thuction weeks Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury monters mass the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ___ ate has been signed by the atter page 2 should be detached for Year Day Pregnant at time of death 1 ☐ Yes 2 2 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an After this certificate has performed No prior to completion of cause of death? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examine: 1 Yes Hospital: Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 Yes 2 No 5 Pending injury by the f Investigation 6 Could not be Accident Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 20a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifi 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) . Age (In yrs. last birthday **Funeral** Day, Y Hours 212-72-8652 49 Director 16, Maryland Aug Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD tyE Yes 2 ☐ No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3rd flr 21231 USA 430 S. Patterson Park Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ⚠ No Black, White, etc. 1 Never Married 2 Married <u>S</u> ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 meat cutter delicatessen other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other the state of the st 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Boyd James Long Sr Sharon Lynn Feltner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Medical Center 301 St. Paul street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or beart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 0 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Monar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 🗌 Yes ☐ Accident Investigation filled in by the 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 1201

State Registrar (Month, Day, Year) APR 3 21203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hargaret H. Walsh, CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 aNU Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 0 51/VEr Mantque If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Birthplace Country) 8. Date of Birth (Month, Day, Year, **Funeral** Min **Director** 1 ★M 2 □ F -26-194 or 28a-f show 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 ¥Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 20 511 1a1 Thiopia Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify 3 ☑ Widowed 4 ☐ Divorced Completed ack 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) tore Be Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) aham IVant 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number tbraham tbraham 20706 Valle 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery crematory or other pla 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses any in Wanda 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 6 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery Live Birth 2 L retail L

Pregnant at time of death in the past 12 months?

1 Yes 2 No Dav Year the 9 Unknown g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has 2 🗌 No 1 ☐ Yes 2 ☑ No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: မှ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, . Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) mpletely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 0052580 2/20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 1500

12-03092 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Maria Lourdes Awatin State of Maryland / Department of Health and Mental Hygiene 1- For State amend #11&20a Per CNFif@92Jo5D84th2012 Jh Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day April 20, 2012 Lourdes Awatin 2052 hrs **Medical Examiner** Maria 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12/13/1961 50 Months Days Hours Min. 571-71-7980 1___M 2___F Director Phointhippines Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f show a notified at once. MD Montgomery Bethesda 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene.

aut: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 20814 6923 Clarendon Road Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 XX Married Yes Asian 3 Widowed 4 X Divorced If Yes, Giva Yaar 1 Yes 2 X No specify: Specify. 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Administration Administrator 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Fidel Samonte Medina Elsa Mababangloob å 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co)4 1 1 2 19a. Informant's Name/Relationship (Type, Print) 5810 Mission St.Apt.404 San Francisco,CA. Itimore, MD Camille Awatin/Daughter 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Straibhbhsus Mary de Liguori Makati City, Philippines 2XX Cremation Sorial Removal from State 5/3/2012 Departion 5 Other Speci 2P PATE POOR PINALDI FUNERAL SERVICE, P.A. 21. Sign eral Service 9241 Columbia Blvd.Silver Spring, Md2091 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. /Medical Death aIntracerebral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, pt. II, 27, per me, g927 5-15-12 sm X UNPENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for 9 Unknown is been signed by the should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Р</u> ੬ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive Atherosclerotic Cardiovascular Disease Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has page 2 performed? death? Yes 2 No 1 🗸 Yes 2 No director, To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one Division of Vital Be Other₄ this o Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes After the 28a, Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural vithin 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) (Specify) Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) EN O.C.M.E. April 21, 2012 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mozelle Anderson 04/07/2012 7:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges **Examiner** Cresent Cities Center Riverdale Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Director 1.1./04/1.928 577-40-7222 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 X Yes 2 No DC 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? Funeral 90018 AZU 2601 18th St., NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pastor Ministry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lossie Bell Battle George Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Browner / daughter 6011 Emerson St.,apt. 105, Bladensburg, MD 20710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 04/25/2012 4 ☐ Donation 5 ☐ Other (Specify Arlington Nat'l Cem Arlington, VA 22. Name and Address of Facility Strickland Funeral Services 21. Signatu vot uneral Servive Li 6500 Allentown Rd., Camp Springs, MD 20748 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aczueinea Jean disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Year Month 4 Pregnant at time of death 9 Unknown been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Derzure Distondor 1) recumonice 1 ☐ Yes 2 ■ No 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA ြုင 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 A Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) meliner ore in D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DEVORE MD 4203 Queenstry Rellty attsville MD 20781

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #23b per MD FCHD TM 4/11/12
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Ralph Boyd Adams 11:45 P M 8 April 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 MM 2□ F Director 229-09-3198 92 March 18 1920 Virginia Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dival Examiner must be notified at 1 ☐ Yes 2 X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3307 Densmore Court 20906 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Na Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced WII White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician U.S. Security Agency 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi Mayo R. Adams Myrtle Pollard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai Janet A. Adams / Wife 3307 Densmore Court, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of l 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Darnestown Presby. 04/12/12 4 ☐ Donation — 5 ☐ Other (Specify) Darnestown, Maryland 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SUDDEM /Medical Due to (or as a consequence of): Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ORCHURRY Due to (or as a consequence of): Examiner burial-transit ATRIAI and Due to (or as a consequence of) Box 68760. nding physician asse as the burial Physician/Medical ENEBRIBI IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 DEctopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2□ No 1□ 1 TYes Division or Vital Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 278 No 1 🗌 Yes 2 ER/Outpatient 2 1 Inpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide ö To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LX CHANCY ROBD SILVER SPRING, Md 20905 BR166 MD NOMB = GLANCY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Owen D. Ague P M April 5:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood @ Crumland Farms Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y **August 18,** 9. Birthplace (State or Foreign **Funeral** 1 X M 2 T Days 84 Months Hours Chio Country) 282-22-8155 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Ohio Trumbull McDonald 28a-1 1 X Yes 2 No 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be n 10g. Citizen of What Country? by Funeral 430 Garfield Avenue 44437 United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Yes 1927-Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced 1945 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Ohio State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Harold Ague Caroline Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Ague / Wife 430 Garfield Avenue, McDonald, Ohio 44437 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 16. 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Girard City Cemetery Girard, Ohio 2012 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home Signature of Jun ral Sen M01433 106 Fast Church Street, Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Unknown Unknown Division of Vital Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) 2 100 Other: Nursing Home 5 - Residence 6 - Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
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Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: Joyne best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 JAI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West Ninth Street, Frederick, Maryland 21701-4541 Casper E. Cline, III, M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

1720

4/11/2012

Physicians as: Owen

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Parker 2 5 201

29b. Signature and title of certifier

one)

32. Registrar's Signature Ener

and manner stated.

2 William Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

April 23, 2012

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Month April 9 2:35 Joseph Butler Atchison Jr. a^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours **Director** 578-42-1486 1 🏝 M 2 🗆 F 80 Usual Residence of Decedent Feb. 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Largo 1 X Yes 2 No Prince George's Marvland 5 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 1077 Largo Road 20774 United States death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 9 þ permit. Page 1 and 2 should be filed within 72 hours after a Department of Heath and Mental Hyglent Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 TNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th unemployed none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hattie Griffin Joseph Butler Atchison Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Burnside- Niece 3572 Fiske Terrace Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) April 14, 4 ☐ Donation 5 ☐ Other (Specify) 2012 incoln 2012 Suitland, Mar 22. Name and Address of FacilityStewart Funeral Home, Inc. Maryland 21. Signature of Funeral Service Licensee John 20019 Washington, DC leway! 4001 Benning Road NE M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTICEMIA disease or condition resulting in death) Medical Examiner Morlia Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury DBSTRUCTION INTESTIMAL and -trar that initiated events law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) burialig physician a as the burial Physician/Medical P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) detached for in the past 12 months? Month Pregnant at time of death Day Year 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, page 2 should 1 Yes 2 No 3 Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate Yes 2 X No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No Other: ဂ္ 1 🕱 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled i Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7325A HAMOVER PARKWAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 20b per fh g926 4-30-12 vt
State of Maryland / Department of Health and Mental Hygiene 0 | 2 13416 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day JANE WINIFRED APFELDORF APRIL 16, 2012 5:50 A

Physician Exa

1 - For State Registrar

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and Division of Vital Records, P.O. Box 68760,

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AMER A BAldi 0433 APRI 7012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical MARYMAND Baltimore lenter ial Security Number 8. Date of Birth (Montal Bay, Year) 02/19/1957 Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours Director 218-72-7111 1 M 2 K F 55 $I_{\rm L}$ Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or ms 23a or must be r Funeral 6248 Gilston Park Road USA 21228 Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
ant, If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner muy 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specif**W**hite If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cardiology Technician Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Donald Eugene Vaile Kathryn Francis Youngmark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,0\,3\,0$ 103 Windy Falls Way Apt M Cockeysville, MD James L. Baldwin/Husband 20c. Location - City or Town, Sta Portland, OR 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1
Department of I
Important; If it
any injury or of 04/21/12 cemetery, crematory or other pla Med Cure Inc. crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility D'Alessandro Funeral H 4522 Butler St. Pittsburgh, PA 15201 Home In. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death signed by the a g 🗌 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 ☑ No death? 1 ☐ Yes 2 ☐ No _ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 M Inpatient 2 ER/Outpatient 3 DOA After this the funeral 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Matural 5 Pending injury 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHMOR South 241664 J(891)6 32 egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:25 AM BOYLAND 04 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Sandy Spring Brook Grove Nursing and Rehab. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 214-07-6901 1 ■ M 2 □ F Yrs. Maryland Jan.25.1915 97 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location at 10a State death with the Maryland Director must be notified 1 🗌 Yes 2 🗬 No Maryland Damascus Montgomery 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number items 23a Funeral United States 20872 10300 Moxley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ed Forces? Yes 2 No 1943-0 1 Never Married 2 Married þ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 1946 "natural", Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Federal Government Standards Engineer 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F rs marked o P Bernadet Lippold James H. Boyland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 10300 Moxley Road, Damascus, Maryland 20872 Mrs. Karen B. Clem, Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery crematory or other place)
Metropolitan
Crematorium, Inc. 1 Burial 2 Cremation 3 Removal from State 04/13/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home M01393 26401 Ridge Road, Damascus, Maryland Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ORONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquantially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician at the burial Physician/Medical death certificate be P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Birth 2 Pregnant at time of death for in the past 12 months? Month Vas 2 No 1 Yes 2 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMONARY EMBOLISM, DIABETES, RENAL 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) CELL CANCER, PROSTAGE CANCER, ATRIAL FIBRE 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. LOUT LCATION, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun, MD

Registrar

DHMH 17 Rev 06-2011

State

10301

31. Date filed (Month, Day, Year)

OR (

32. Registrar's Signature

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ AMonth Dradi 0038 AM tayman 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death enter 6. Sex ocial Security Number If Under 24 Hrs. . Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign PA **Funeral** 1 🗆 M 2 🗶 F Months Days Min APRIL 7, Director 196-44-2318 58 Usual Residence of Decedent 28a-f show 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD OUEEN ANNE'S CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 CLOVELLY LANE UNITED STATES 21620 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify. Completed 3 Widowed 4 Divorced Year or Dates WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည WARREN HAYMAN JEANETTE NISSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 short Health and tem 27 is n CHRISTOPHER A. BRADY / HUSBAND 200 CLOVELLY LANE CHESTERTOWN, MARYLAND 21620 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 04/04/2012 STEVENSVILLE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause one ach line. Approximate shock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Cour 215 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Examin Koun to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 2 🗌 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Others 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) work? Natural 5 Pending injury 2 No Accident М Investigation Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 2012 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Treet 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#5 per FH 4/17/12 Continuate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VARTHUR BUTLER 04/07/2012 :29 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2412 Corning Avenue Prince George's Ft. Washington Social Security Number 330-73-1451 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Director 1 X M 2 D F Yrs 11/13/1967 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f sho 10b. County notified at the Maryland Director Ft. Washington 1 X Yes 2 No MD Prince George's 10e. Street and Number 10g. Citizen of What Country? ö "natural", or items 23a or dical Examiner must be Funeral 20744 2412 Corning Avenue AZU Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces' Black, White, etc ρ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene.
27 is marked other than "I rraumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) 75 <u>Reservation Manager</u> World Trade Center Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Carl Smith Delorise Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other to Carl W. Smith / father 2412 Corning Ave., Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery 04/14/2012 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Cemetery 21. Signatu e of uneral Service 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 17 months Non Hodgkins Lymphoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Acquired Immune Deficiency Syndrome Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: 1 ☐ Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20542 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Washington N.W. D.C. 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECKETI Medical Facility Name (if ng) hstitution, give street Examiner Town or Location of Death County of Death USbury 100 100 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Months Days 1 🗆 M 2 💢 F Hours Min nth, Day, **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 □ No JUMICO ō 10e. Street and Number 10. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral OAd 801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. and Mental Hygiene. is marked other than "natural", Specify: Completed 3 Widowed 4 Divorced BIGCK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ injury or other traumatic 1 NO Ida ARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Page 1 and 2 20 M MSU lle 24112 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) comoke City ma nature of Funeral Service Licensee 22. Name and Address of Facility hapton harton 23301 CComac 100 Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Irhmediate Cause (Final Onset and Death Physician/ 2ES disease or condition Medical resulting in death) o (or as a consequence of): Due Examiner Sequentially list conditions Examine Dualty for as a consequence of, if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?

1 Yes 2 No be detached for Month Dav Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death2 þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy prior to completio death? this certificate has 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗆 Yes 2 1 No ျှ ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical fitiging Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

BA3

State Registrar

DHMH 17 Rev 7/2009

SHORE

death (Item 23a) (Type, Print)

strar's Signature

32.

3 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended, #1	State of Maryla Qeo r State TCHD, 04/05/2012 Registrar	and / Department of He $ m ^{TLS}$ Certificate of De	ealth and Mental Hygic eath	ene Reg. No. 2012 1342						
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	zabeth Bis	hoff	ate of Death onth Day Year oril 2, 2012 3. Time of Death 0105 hrs						
	4a. Facility Name (if not institution, give street and nu Harmony Road south of Grove Road		ty, Town, or Location of Death	4c. County of Death						
Funeral	5. Social Security Number 6. Sex			Caroline Date of Birth(MM/DD/YYYY) 9. Birthplace (State or						
Director	216-25-8703 1_M 2XF	27 Yrs. Mo	onths Days Hours Min. 0	6/04/1984 Foreign Country) Md.						
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits						
Maryland 28a-f show d at once.	Md. Caroline	Den		1 Yes 2 X No						
with the Maryland ss 23a or 23a-f sho ex notified at once. ral Director	10e. Street and Number Pealiquor 25156 Pealiquor Road		Zip Code 21629	10g. Citizen of What Country? U.S.A.						
r death with , or items 23 .must be no Funeral	1 X Never Married 2 Married Armed Fo	orces? If Yes, sp	edent of Hispanic Origin? (Specify ecify Cuban, Mexican, Puerto Ricar							
s after de iral", or incr m	3 Widowed 4 Divorced If Yes, Give Yea		2 No specify:	Specify: White						
2 hours "natured Exam	15. Decedent's Education (Specify only highest grad Elementary/Secondary (0-12) College (1	during most of	ual Occupation (Give kind of work d working life. DO NOT use retired)	one 16b. Kind of Business/Industry						
5-0036 ed within 72 hour stygene. other than "nati	12 2	Ar	tist	Freelance Art						
215- be filed ntal Hyg rked off	17. Father's Name (First, Middle, Last) Paul J. Bishe	off		, Middle, Maiden Surname) Bridges						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Stacy Bishoff/ Mother	19b. Mailing Addre 7890 Qu	ess (Street and Number or Rural F aker Neck Rd., B	Route Number, City or Town, State, Zip Code)						
ore, N. s. 1 and of Health Litem	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	20b. Place of Disposition (I	ice)							
Itimo iit. Page artment ortant: ry or oth	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Crem. of De								
	Joseph M. Ostrowski C	1 P.U.	end Address of Facility By & Ostrowski Fi Box 518 St. Micl	naers, Ma. 21003						
Physician /Medical	23a. Part I. Enter the disease, or complications that confailure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Inju		de of dying, such as cardiac or respi	iratory arrest, shock, or heart Approximate Interval Between Onset and Death						
£xaminer	or condition resulting in death) Due to (or as a consequence of):									
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a cause. Enter Underlying Cause									
ted Insit Examiner		consequence of):								
Records, P.O. Box 68760, The law requires that the death certificate be executed teate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Completed by Physician/Medical Exit	UNPENDED d.									
68760 ertificate the ding physical the bulleton ian/Me	23b. Was decedent pregnant in the	outcome of pregnancy	th 3 Ectopic pregnancy	23d, Date of delivery Month Day Year						
Box 6876 be death certificate the attending phy the after use as the the Physician/M	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	ant at time of death 5 Other (S								
P.O. Bo that the de med by the detached f	Part II. Other significant conditions contributing to			3e. Did tobacco use contribute to the cause of death?						
ords, P.O. Iw requires that the as been signed by the Should be detached pleted by Pl				1 Yes 2 No 3 Probably 4 Unknown 4a. Was an 24b. Were autopsy findings available						
Records, The law require ficate has been sig. page 2 should be				autopsy prior to completion of cause of performed?						
tal Rectifica	25. Was case referred to medical examiner?		26 Place of Death (Check only or							
n of Vital Reco	1 Yes 2 No Pospital 1 Ir	npatient 2 ER/Outpatient 3 Df Injury 28b. Time of Injury	DOA Other Nursing Hom 28c. Injury at Work? 28d. [e 5 Residence 6 V Other: Scene						
C = : = 1 D1	1 Natural 5 Pending FOUND: 2 ✓ Accident Investigation Apr 2, 20	FOUND:		er in auto collision						
Division of Vital ospital or Attending Physician: hours after death. Internal Director. After this certify filled in by the funeral director Certification: To Be	o Conid lot be	of Injury - At home, farm, street, facto Local Street	Oi	ocation (Street and Number or Rural Route Number, City r Town, State) ony Road south of Grove Road, Preston, MD						
O File Bound	29a. Certifier (Check only 1 Certifying Physician: To the best	of my knowledge, death occurred at t	the time, date and place, and due to	the cause(s) and manner as stated						
To the He within 24 To the Fe completel	2 Medical Examiner: On the basis of and manner st	ated	my opinion, death occurred at the til	me, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)						
	()/ Colorleul)		O.C.M.E.	April 2, 2012						
15										
4	30. Name and address of person who completed cause	e of death (Item 23a) Examiner 900 W. Baltimo	re Street, Baltimore, MD 2	1223						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item II per in 928 6-1-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death _____2<u>012</u> Physician/ APRIL DENNIS LINARD BRIDGES 11 20:46 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, **Funeral** Director 579-13-1683 24 JUNE WASHINGTON, DC 1987 Usual Residence of Deceden 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 No MD **CHARLES** BRANDYWINE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 23a **Funeral** 15095 REGINA AVENUE 20613 UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or item Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced "natural" Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **SERVER** FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROBERT DENNIS WATSON MAE E. BRIDGES YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAE E. YOUNG/MOTHER 15095 REGINA AVENUE, BRANDYWINE, MARYLAND 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 101 F i X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury of HERITAGE MEMORIAL CEMETERY 4/20/2012 4 Donation 5 Other (Specify) WALDORF, MD 21. Si Cum rai Server Linguese Questin MOO583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ Medical PNEUMONIA PNEUMOCYSTIS disease or condition resulting in death) Due to (or as a consequence of) ACQUIRED IMMUNE DEFICIENCY SYNDROME Examiner osquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Day Year Yes 2 No should be detached a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 autopsy performed' 1 🗌 Yes 2 **N**0 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DO 064986 0/2

State Registrar 31 Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ ROBIN LYNN PROCTOR BOWMAN APRIL 10. 2012 7:27 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. MARY'S MARY'S HOSPITAL LEONARDTOWN If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours 1 M 2 X **APRIL** MARYLAND Yrs. . 1985 Director 215-08-6785 27 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No LEXINGTON PARK MARYLAND ST. MARY'S 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral UNITED STATES 20653 47449 LINCOLN AVENUE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE BUS AIDE TRANSPORTATION other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JUANITA THERESA PROCTOR THOMPSON JOHN ROBERT PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MAURICE N. BOWMAN, SR./HUSBAND 47449 LINCOLN AVENUE, LEXINGTON PARK, MARYLAND 20653 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State BRINSFIELD-ECHOLS CREMATORY APRIL 14,2012 CHARLOTTE HALL, MARYLAND 4 Donation 5 Other (Specify) 21. Si set, re of Funeral Service Lice yee THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, LYDIA C. THORNION JOHNSON MO0583 MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician standstill contingulmenery disease or condition resulting in death) Vertraler settenlary monutor Medical Due to (or as a consequence of): Examiner merbed obesity 4 ches Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Sleep amos 4 cars and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown g Unknown P.O. ed by tl signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an bage 2 s autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State

29b. Signature and title of certifie

31. Date filed (Month

inhart

Registrar

DHMH 17 Rev 7/2009

Hospital

140

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

1212

29c. License number

D0068540

524

Leenard town

P.O. Box

29d. Date signed (Month, Day, Year,

10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster 9. Birthplace (State or Foreign Country) MI If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 02/13/1937 1 🗶 M 2 🗆 F **Director** 12-40-7185 75 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral 21158 Carroll 936 Hughes Shop Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White If Yes. Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Fire Department Pump Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked o ည Louise Root Roy L. Baker Page 1 and 2 should be other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a: If item 27 i 598 Noland Drive, Sykesville, MD Janice Maisel/daughter 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1X Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cem. 04/24/2012 Westminster, MD of Funeral Service L 22. Name and Addprifts Funeral Home and Chapel, P.A. 412 Washington Road, Westminster, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 10 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? 1 ☐ Yes 2, ✓ No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, To Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation 6 🗌 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practition To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 06-2011

21117

person who completed cause of death (Item 23a) (Type, Print)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monti 04 6:50P M Clair 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Montgomery Wheaton Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 💢 Months Hours Min. (Month, Day, 12 03 Country) Director 059-50-4472 88 Jamaica Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c, City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Directo 1 X Yes 2 No Takoma Park MD Montgoemry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7611 Maple Avenue 20912 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, or than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. Ş 1 XNever Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Nurse's Aide 12 Private Duty Be permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked ot
any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Hilda Cover Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverley Reid/Niece 1802 Longfellow St. Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 04/21/2012 Brentwood, MD ignature of Funeral Service Lice 22. Name and Address of Facility Marshall-March Funeral Home 9th St. NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit transit C Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 2 X No Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2 🗶 No Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D57761 04/07/2012

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State

30. Name and address of person who completed cause of

Alan R Segal, MD

31. Date filed (Month, Day, Year) APR 13 2012 Hugo Circle Silver Spring, MD 20906

eath (Item 23a) (Type,/Print)

151

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 10, 10:00 A M April Avon Powers Ciufolo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under Year 7. Age (In vrs. last birthday) if Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign \$243-16-4063 **Funeral** Days Hours Min (Month, Day, Year) Director 1 🗌 M 2 🛢 F 90 May 20, 1921 North Carolina Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location with the Maryland aţ 10a. State 10d, Inside City Limits Director notified 1 Yes 2 No Maryland Howard Woodbine 10f, Zip Code ems 23a or r must be r ō 10e. Street and Number 10g. Citizen of What Country? Funeral 3606 Woodbine Road 21795 United States items 2 death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hugh C. Powers Mary J. Sawyer Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Joann A. Ciufolo, Daughter 6308 Tulsa Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan
Crematorium. Inc. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 04/13/2012 Alexandria, Virginia 22. Name and Address of Facility
Molesworth-Williams, P.A.,
26401 Ridge Road, Damascus, Funeral Home , Maryland 20872 Mol393 26401 Ridge Road, Damascus, drhe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of) physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month
1 Yes 2 No
9 Unknown jo Year Month Day Pregnant at time of death signed by the ail of the beat of the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes 1 X Inpatient 2 DER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MV D68108 he 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar DHMH 17 Rev 06-2011

State

Kinnaird,

32. Registrar's Signature

Alexander N.

th, Day, Year

31. Date filed (Month

18101 Prince Philip Drive, Olney, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SUSANNE MIDDLETON APRIL 12 ay 2012 a 11:25 рм CRADDOCK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14574 Fox Hole Rd. Galena Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min 577-50-0910 78 Michigan 1934 Director Usual Residence of Decedent 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Kent Galena 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö rral", or items 23a or Examiner must be I Funeral 14574 Fox Hole Rd. 21635 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Research Assistant Radiation Oncology marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of ည Glenn Middleton Ethel Sloat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i Susan E. Brown (daughter) 2342 Miller Rd. Chester Springs, PA. 19425 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal injury or Kent Cremation Services 4/13/12 on 5 Other (Specify Smyrna, DE. 4 Dona Funera Service 21. Si Calena Funeral Home of Stephen L. any 1400510 118 West Cross St. Galena, MD. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate k. or h art failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or conditi resulting in heath) Medical Due to (or consequence of Examiner MC if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician sthe burial-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No the 9 Unknown 9 Unknown Records, P.O. þ signed b Part II. Other significant conditions contributing to de but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b I director, page 2 sh autopsy death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: Nο ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Funeral Director: After to completed filled in by the funera Natural 5 Pending work? 1 Yes 2 No death. Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hours after Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 24 3 Certifying Harse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3 İ 12 0051786 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Ferguson, M.D. 120 Speer Rd. Chestertown, MD. 21620

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>012</u> 8:30 A Physician/ APRIL 7 WILLIAM CHRISTIAN Médical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FORESTVILLE NURSING & REHAB CENTER FORESTVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours 577-66-9896 **Director** 1 💢 M 2 🗆 F 62 08-31-1949 DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD PG CAPITOL HEIGHTS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 404 71st Funeral STREET US 20743 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SECURITY GOVERNMENT 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM G. CHRISTIAN COLLEEN HOLLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STREET. CAPITOL HEIGHTS, MD 20743 MARILYN CHRISTIAN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04/17/2012 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE PARK CREMATORY RIVERDALE, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. . Signature of Funeral Service Lio 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Macerebra Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ancer attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe has le 2 1 ☐ Yes 2 ☐ No Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other ၉ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Valursing Home 5 Residence 6 Other (Specify) Certificate: Mann 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After (Month, Day, Year) iniury Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certitier 29c. License number 29d. Date signed (Month, Day, Year) 000 -10-2012 00070693

Registrar DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		
State of Maryland / Department of Health and Mental Hygiene	2012	1
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		-For State Amend#19a per FH TT <i>C&rfti</i>	ilio@ilelof Dea	th		_{J. No.} 201	2 3431		
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last) Jose Osmin Lainez Canales			2. Date of Death Month	Dav Year	3. Time of Death 0955 hrs		
legicai Exami	ner	4a. Facility Name (if not institution, give street and number)	4b. City,	Town, or Location of D	April 10, 20	4c. County of Death			
		8201 16th Street	Beth	Bethesda Montgomery					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Und Mont	der 1 Year If Under 2 hs Days Hours	4Hrs. 8. Date of Birth Min. 04/02/		hplace (State or n _{Intry} Honduras		
Director		None 1X _{M 2} F 30	Yrs.	Days Moure	04/02/	1962 Cor	untry) 1011dat as		
any	- }	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits		
.		Maryland Prince Georges Seat	Pleasant				1 X Yes 2 No		
Aaryland 28a-f show I at once,	ecto	10e. Street and Number	10f. Zi	p Code		g. Citizen of What Cour	ntry?		
3a or		1103 Glenn Willow Dr. #10		0743	1	Honduras			
ath with	Funeral Director	11. Marital Status 1 Never Married 2 X Married Armed Forces?	ent of Hispanic Origin? ify Cuban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,			
ter de:		Never married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1X Yes	2 No specify:HC	onduran	specify: Whit	æ		
ours a	d b	15. Decedent's Education (Specify only highest grade completed)		l Occupation (Give kind orking life, DO NOT use		16b. Kind of Business/I	ndustry		
36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Construct:	•		Potomac Aba	atment		
d with ygiene ther t	Ę	17. Father's Name (First, Middle, Last)	Comperator		lame (First, Middle, M	aiden Surname)	-		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	Jose Lainez Banegas				uinones			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiewith. Important: If item 7.7 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	P	19a Informant's Name/Relationship (Type, Print) Yudy Yudu Marisela Cardenas Reyes	19b. Mailing Addres 1103 Glei	s (Street and Numbe on Willow I	ror Rural Route Numb Dr. #10 Se	oer, City or Town, State at Pleasant	, Zip Code) C, MD 20743		
e, K I and 2 Health item 1	5_24	20a. Method of Disposition 20b. Pla	ace of Disposition (Na ematory or other place		Date	20c. Location - City or Nacaome Va			
Pages ent of nt: If		Abuna 2 Cremation Administrate	eno Blanco	\int_{0}^{∞}	4/16/2012	Honduras			
Baltimore, permit. Pages 1 and Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	22. Name an	d Address of Facility	Rendon/Ha	le Funeral , MD 20706	Home		
Physician		23a. P. T. Enter the disease, or completions that caused the death. D					Approximate Interval		
/Medical		lailure. List only one cause each line. Immediate Cause (Final disease a. Multiple Injuries					Between Onset and Death		
Examiner		or condition resulting in death) Due to (or as a consequence of):							
	P	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
ccuted and transit	Exa	events resulting in death) Last Due to (or as a consequence or).					10		
e exectican an cian an rial - tr	Medical	UNPENDED AMENDED		-					
760, icate be ex physician the burial	/Me	IF FEMALE: 23c. If yes, outcome of pregnat 23b. Was decedent pregnant in the		3 Ectopic pi	reanancy	23d. Date of delivery	/ Day Year		
Box 687 e death certific the attending p ed for use as th	cian	past 12 months? 4 Pregnant at time of deat	2 Fetal death th 5 Other (Sp		regriancy	I Monar			
b,O, Boy that the death ned by the att detached for	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			200 Did tol	bacco use contribute to	the cause of death?		
, P.O. res that the signed by be detach	by P	Part II. Other significant conditions contributing to death but not res	suiting in the underlying	ig cause given in Parti		2 ✓ No 3 Prol			
ds, Fequires een sign	eted				24a. Was a		topsy findings available		
cords law requi	Completed				autops perform 1 ✓ Yes 2	med? death?	completion of cause of		
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical		26.Place of Death (C			2 110		
Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 E	ER/Outpatient 3	DOA Other		Residence 6 🗸 Othe	r: Scene		
n of V ding Pb.	on: T	(Month Day Year)	28b. Time of Injury 0933 hrs	28c. Injury at Work? 1 ✓ Yes 2 N	Subject fell f	ow injury occurred rom height while a	at work		
Sion Attend r death ector: by the	cati	2 Accident Investigation 28e Place of Injury - At hor	ne, farm, street, facto			treet and Number or Ru	ıral Route Number, City		
Division pital or Attent ours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Apartment b			or Town, St 8201 16th Stre	ate) eet, Bethesda, MD			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only	e, death occurred at the	ne time, date and place	e, and due to the cause	e(s) and manner as stal	ed.		
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier		ny opinion, death occu 9c. License number	ned at the time, date a	and place, and due to tr			
10	2	All 1 11. 1 +1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	O.C.M.E.		April 11, 2012			
9		30. Name and address of person who completed cause of death (Item 2	23a)	-		<u> </u>			
10)	Theodore M. King, Jr., MD. Assistant Medical Ex	xaminer 900 V	V. Baltimore Stree	et, Baltimore, MC	21223			
	tate	31. Date filed (Month, Day Year) 2 32. Registrar's Signature	bare						
Regis	wel	Will - A - Co C			Charle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13431 1-State Registrar 10e, 19b, FH, 4/2/12, rls Amended# Certificate of Death 2. Date of Death 3. Time of Death Physician/ 2012 ROBERT GEORGE CHEEZUM MARCH 29 3:15A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 - F Months 12/09/11/92/2 89 MARYLAND 216-14-9710 **Director** Yrs Usual Residence of Decedent 28a-f show 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT EASTON 10e, Street and Number 10f. Zip Code Apt76 10g. Citizen of What Country? Funeral 606 DIAMOND STREET 201 Federal USA St 21601 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗓 No "natural", 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the SHIPPING CLERK E.S. ADKINS Be 17. Father's Name (First, Middle, Last) should be file and Mental H is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) ပ WILLIAM WALTON CHEEZUM MINNIE FISCHER 19b. Mailing Address (5) 1967 and Namebel & Fred Foute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i CORNELIA CHEEZUM/SPOUSE 606 DIAMOND STREET EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEARE) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CENTER 03/30/2012 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELTOWSAGINETFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET EASTON, MD 21601 MERLEROD JOHP R. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ARTERIAL THROMBOSIS RIGHT UPPER EXTREMITY Medical Examiner ATHEROSCIEROTIC CARDIOVASCULAR DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p for use as t IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ISCHEMIC CARDIOMY ODATHY ATRIAL FIBRILLATION Records, 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natura! 5 Pending work? 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettiying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

of Vital Division within 24 hours after death

To the Funeral Director: A
completed filled in by the f To the Hospital

RSIOHIVA State Registrar

ed cause of death (Item 23a) (Type, Print)

only one)

ATTENDING MD

00053094

3-29-2012

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Allan 10:37 PM I. Chotiner April 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Lanham Prince George's Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Aug. 26,1915 192-12-9947 Pennsylvania 1 X M 2 D F 96 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Oa. State at Director ems 23a or 28a-f sh r must be notified a Maryland Prince George's College Park 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7405 Baylor Avenue 20740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. Chotiner, Allan Baltimore, Maryland 21215-0036 5 1 Never Married 2 Narried þ 1 ☐ Yes 2X No Specify. White If Yes, Give Year or Dates.1943-1945 "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Prince George's Co., MD College (1-4 or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Deputy Superintendent Schools injury or other traumatic event, Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Chotiner Gertrude Recht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Ann B. Chotiner -wife 7405 Baylor Avenue College Park, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 4/23/2012 Silver Spring, Maryland Signature of Funeral Service License Donaldovie Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death ed by the ar 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death?
1 Yes 2 No Yes 2 No the Hospital or Attending Physician: Was case referred to medical funeral director, 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) Manney of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed c Hector E . Knox 111 Hospital -anhan, Maryland Doctors 8118 Road Good 31. Date filed (Morning)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 09 2012 4:45 P M Lilliette Theresa Dube Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Elkton Care and Rehabilitation E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🖾 F Months Days Hours 1/29/1927 Director 85 Maine 005-20-7233 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Earleville MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a USA 3 Maine Avenue 21919 death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 2 No Yes, Give Black, White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify Specify: White 3 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Waitress Food Service and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jeannette Bouchard Emile Laffely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n Camp Stewart Road, Charlotte, NC 28215 Jeanette Winslow - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 04/12/2012 4 Donation 5 Other (Specify) Foard Funeral Home, PA Rising Sun, MD Signature of Funeral Service 22. Name and Address of Facility R.T. Foard Funeral Home, PA 318 George Street, Chesapeake City, MD 21915 3a. Part 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ CHASNIC 065614 AIRDAY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CONGESTIVE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami or Attending Physician: The law requires that the death certificate be executed ATRIAL ABRILLATION and -trans Due to (or as a consequence of) resulting in death) Last physician a the burial-Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a g Unknown g 🗌 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Tyes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) To the Hospital Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number V. Norto D0065733 4/13/12 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAS V PULA FLKTON HD 21921 A s ment. NARMANA 116 171411 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 11,2012 Year Physician/ 10:37 A M Nola Louise Day Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under MN Country) **Funeral** Hours Feb. 1, 1928 84 475-22-4186 **Director** 1 M 2 XF Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a, State 10c. City, Town or Location rector notified Chevy Chase MD Montgomery 1 X Yes 2 No ō 10e. Street and Numbe 10f. Zip Code or 10g. Citizen of What Country? Examiner must be Funeral items 23a 5100 Dorset Avenue 20815 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 5+ US Diplomat Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Sarkis Louise Gjertsen permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic eonee. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Maryland Ave., NE #202, Washington, DC 20002 Erin Day/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State April 18, 4 Donation 5 Other (Specify) Metropolitan Crem. Alexandria, Va. 21. Signature o veral Service 22. Name and Address of Facility DeVol Funeral Home MO1315 ralle 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician a ar tenosclerotic cordiovascular disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death ed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Hospital or Attending Physician: The law autopsy performe A ler this certificate has funeral director, page 2 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1. Natural iniury 5 Pending To the Hospital Society within 24 hours after death.

To the Funeral Director: After the Funeral Director: After the funeral filled in by the funeral process. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barks

Geo Je town Ro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Főr State Registrar Certificate of Death 1. Decedent's Name First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month 3:20A M Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Health Coure ata now If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 47 WASH Director Yrs Usual Residence of Decedent 28a-f shov 10b. County 10a. State should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director notified MD. CHARLES LA PLATA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code or items 23a or 10g. Citizen of What Country? Examiner must be by Funeral 1 MAGNOLIA DRIVE 20646 CHARLES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify:WHITE 3 Widowed 4 Divorced Completed 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOCTOR'S OFFICES NURSING ASST. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE WILLIAM RIGGS KAREN ANN REDMAN Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAURIE McCLURE-DAUGHTER 8923 HEATHERMORE BLVD. UPPER MARLBORO, MD. Page 1 and 2 item 2 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20773 Date ď Important: If it any injury or c 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) MET cemetery, crematory or other place) METROPOLITAN CREMATORY 4-3-12 22. Mme and Address of Facility Signature of Faneral Service License M/00479 RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, cute renal Korure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Posture Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4 Pregnant 9 Unknown Day Month Year Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes After t Certificate: 28d. Describe how injury occurred **Natural** injury 5 Pending 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dyr g926 4-27-12 yearth and Montal Hydrone.

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a sugar	Examir		4a. Facility Name (if n		street and number) S HOSPIT	י דגי	משועם	4b. City, Town, c		of Death			County o		ORGE'S	
	Funeral		5. Social Security Nur				ast birthday)	If Under 1 Year	If Under		8. Date of Birl	th	XIIVCI		ace (State or Foreig	an
	Director		579-36-4		Ç M 2 □ F	8	0 Yrs.	Months Days	Hours	Min.	(Month, Da		32	Countr	I.,DC	3,,
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Baltimore,	Page tment tant: I jury o		4 Donation 5	Other (Specify	Removal from State	SĂ	CRED	HEART C				LA	PLA	ΓA,	MD	
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	ral Service License	Slo	MOO	641 50	Name and Address	ss of Facility	RAY	MOND I	TUNI	L. SI	ERVI	CE, P.A.	
			23a. Part 1. Enter the shock, or heart	disease, or complailure. List only on	lications that caused e cause on each line	the death		the mail of dyin	g, such as o	cardiac or	respiratory arr	ont.	TULI		Approximate nterval Between	
Law.	Physician .		Immediate Cause (Fir disease or condition		a Ce	ze	bra	Vin	fa	22	lee	ند. حر			Onset and Death	
	Medical Examiner		resulting in death)		Due to (or as a	a consequ	ence of):									
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	cate be executed physician and s the burial-transit	la E	resulting in death) Las	st .	Due to (or as a	consequ	ence of):									
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× 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		IF FEMALE: 23b. Was decedent pr	ognani	3c. If yes, outcome of			Ectopic pregnance	3/				23d. Date	of delivery		
Box	e death the ath thed fo	ysici	in the past 12 mo 1 ☐ Yes 2 ☐ I 9 ☐ Unknown		4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)	· y				Month	n D	ay Year	
P.O.	hat the		Part II. Other significa	ant conditions cor	ntributing to death bu	ut not resu	ılting in the un	derlying cause giv	en in Part I.		23e. Did to	bacco u	se contribu	ute to the	cause of death?	\dashv
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_	g Phy er this neral d	e: 10	27. Man/er of Death		28a. Date of injur	у :	R/Outpatient 28b. Time of	28c. Injury	4 ∟ Nur at		e 5 Reside			Specify)		-
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N	or Att after d Direct in by	Certificate:	4 Homicide	6 Could not be determined	28e. Place of Injui building, etc.		ne, farm, stree	t, factory, office		28	f. Location (St City or Towr			r Rural Ro	oute Number,	
	spital nours neral y filled		29a. Certifier 1	Certifying Physic	cian: To the best of r	nv knowle	dae, death oc	curred at the time	. date and r	place and	due to the cal	ica(c) ar	nd manner	as stated		-
	the Ho nin 24 l the Fu	Medical	(Check 2 4 only one) 3	Medical Examine	er: On the basis of ex Practitioner: To the	amination	and/or investig	ation, in my opinio	n, death occ	curred at th	e time date an	d place	and due to	the cause	(s) and manner state	ed.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 1320 Shirlee Ellen Ehrenberg 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sandi Brooke Grove Assisted Living- The Meadows Montgomer 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🗓 F Days Hours (Month, Day, Ye 89 Director 031-16-6287 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Silver Spring 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 512 Whitingham Drive 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3X Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of ၉ Rachel Unknown Harry Koretsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s Daniel S. Ehrenberg - Son 512 Whitingham Drive, Silver Spring, Maryland 20904 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-15-2012 Boston Massachusetts Crawford St. Mem. Park 21. Signature of Funeral Service Cicensee Edward Sage1 22. Name and Address of Facility Danzansky-Goldberg M00910 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ a chronic obstructive pulmonary disease disease or condition ears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det ş SICK Sinus Syndrome Records, disease ! Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No ation this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 7

State Registrar

31. Date filed (Month, Day, Year)

13

Box 68760

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gave Brooke Huffman, M.D. 18100 Stade School Kord Sandy

Records, Division or Vital After death. hours after

page 2 should To the Hospital or Attending Physician: funeral director, To the Funeral Director: within 24

Completed autopsy performed2 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 7 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier

D 39793

29d. Date signed (Month, Day, Year) April 10, 2012

30. Name and address of person mpleted cause of death (Item 23a) (Type, Print)

Christopher J. Mays, M.D. 18111 Prince Philip Drive, Olney, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ RICHARD 15° 2012° D. ELBURN APRIL 1:20 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kent Chestertown Nursing & Rehab Chestertown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 D F Hours (Month, Day, Aug 19 Director 1922 Maryland 217-30-8225 89 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Kent Chestertown 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ems 23a or r must be r Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 125 Clipper Way 21620 Ŭ.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ed Forces Black, White, etc. by 1 Never Married 2 K Married X Yes Maryland 21215-0036 2 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Specify Completed WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Walter L. Elburn Molly Ringgold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Elburn (wife) 125 Clipper Way Chestertown, MD. 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Chester Cemetery 4/18/12 4 Donation 5 Other (Specify) Chestertown, MD. 22. Name and Address of Facility Galena Funeral Home of Stephen L. 21. Signa M00510 118 West Cross St. Galena, MD. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heart failure. List only one cause Interval Between Onset and Death Immediate ause (Final Physician/ aslas disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and do be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: Natural 5 Pending Accident Investigation 24 hours after deat Accider
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 only one 29b. Signature and title of certifie 29d Date si 12

DHMH 17 Rev 7/2009

State

Registrar

Chestertown, MD. 21620

516 Washington Ave.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Ros.
Day, Year)

APR 2

Susan K.

			For State Registrar	State of Ma	arylan	d / Depa <i>Cer</i>	artment of F <i>tificate of L</i>	lealth Death	and M				12	1341	+ 0
П	Physicia	n/	1. Decedent's Name (First, Mide	,						2. Date of Dea			oor	3. Time of Death	
, pic self	Medic Examin	al	Philip 4a. Facility Name (if not institution)	Friedman			4b. City, Town, or	Location		April 5		.012	ear	306 AM	M
200	Examin	E	Holy Cross Hos				Silver					c. County of lontgo			
	Funeral Director		5. Social Security Number 577-40-9577	6. Sex 7. Age	(In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Day	v, Year)		Countr		-
			Usual Residence of Decedent	8.7		Yrs.				08/27/1	1924			hington Be	
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	the Marion 28	1 Dire	10e. Street and Number	regomery		211/61	10f. Zip Code			Τ	10g. Ci	itizen of Wha	at Count	11.	INO
	th with ns 23a must b	Funeral	10607 Meadowh				20901				Uni	ted S	tate	S	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 🛣 Marital 3 ☐ Widowed 4 ☐ Divorce	If You Give		If	Vas Decedent of Hi Yes, specify Cuba	n, Mexicar	n, Puerto R	ify Yes or No- ican, etc.)		14. Race - Black, \ Specify:	White, et		
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and	be filed v lental Hyg rked othe iic event,	To Be	17. Father's Name (First, Middle, Joseph Friedma						er's Name	First, Middle, I	Maiden	Surname)			
aryl	ind Me s mark umatic		19a. Informant's Name/Relation			19b. Mailin	g Address (Street a				City or	r Town State	Zin Co	de)	
Ž,	I and 2 should be file f Health and Mental H tem 27 is marked o other traumatic eve		David Friedman	n - son			Mayfair								
Baltimore,	Page nent c ant: If iry or	j	4 Donation 5 Other		CE	emetery, crem	sition (Name of latory or other plac 1. Garden	e) S	04/08	ate 3/2012		ocation - Cit	-	n, State	
Ba	permit. Departr Importa any inju	V	21. Signature of Funeral Service		477		Name and Addres			lemoria	1 C	hapels	s. In	Saara	
П			23a. Part 1. Enter the disease, of shock, or heart failure. List	or complications that caused only one cause on each line.	the death							VIIIE	/	Approximate nterval Between	T
~ 1	Medical	s v	Immediate Cause (Final disease or condition resulting in death)		sis									Onset and Death	
	Examiner			Due to (or as a	eller ber	ence of):									
	D 5	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	-										
	xecute	Exar	that initiated events resulting in death) Last	c. Ren		ailure ence of):							1	·	
09/	icate be executed physician and is the burie transfer	ledical		d											
189	ertifica ding ph se as t	/Me	IF FEMALE:	23c. If yes, outcome o	f pregnar	ncv					Т				
ROX	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunidarians.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	🗀 Fetal	Ideath 3 🗌	Ectopic pregnance Other (specify)	у				23d. Date o Month		ay Year	
, ک	s that igned b	2	Part II. Other significant condit					en in Part I	l.					cause of death?	
Spuc	require been s should	eted	Encephalopat	hy, decub ulo	er_w	ith MR	.SA			1 Y		1		bly 4 Unkno	
II Kecords,	n: The law ificate has or, page 2	e Completed	25. Was case referred to medica			_	as Dia	on of Door	th (Ohaalia	24a. Was a autops perfor	sy	prior	to com	y findings available of cause o	f
or Vital	nysicia nis cert I direct	To Be	examiner? 1 ☐ Yes 2 【XNo	Hospital: 1 🔀 Inpatie	nt 2 🗆 E	ER/Outpatient		r.	th (Check o	e 5 🗆 Reside	ence 6	Other (S	pecify)		
ion of	tending Plath. Ior: After the funera	Certificate:	27. Manner of Death 1 X Natural 5 Pend 2 Accident Invest 3 Suicide 6 Could	ing 28a. Date of injury (Month, Day,	Year)	28b. Time of injury	28c. Injury work? M 1 🗆	at ? Yes 2 🗆		d. Describe ho	ow injury	y occurred			
UIVISION	al or At s after o		4 Homicide determ		y - At hor <i>(Specify)</i>	ne, farm, stre	et, factory, office		28	lf. Location (St City or Town			Rural R	oute Number,	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 ☐ Medical only one) 3 ☐ Certifyin	g Physician: To the best of m Examiner: On the basis of exa g Nurse Practitioner: To the	amination	and/or investig	gation, in my opinior death occurred at th	n, death oc ne time, dat	curred at th	e time, date an	d place.	and due to t	the cause	e(s) and manner sta	ated.
	D IN C IS			una co	/		29c. License D6082			2	9d. Dat	te signed (M il 5,	2012	y, Year)	
			30. Name and address of person					C	na Mr	20010					
	Stat	е	31. Date filed (Month, Day, Year)	MD 1500 Fores 2012 3. Registrar	s Signat			spri	ng MI	<u> </u>					
	Registra	r	HEU TO	2012 Centur	<u> </u>	4100	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M4711/2012 8:15 a M CORNELIUS FAIRBANKS FREEMAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda, MD Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 243-52-8388 **Director** 1 XM 2 F Yrs 2/18/1938 74 NC Usual Residence of Deced 28a-f show Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 No 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 20904 1109 Morningside Drive USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" Completed 3 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Asst. Principal-Howard Cty Education 6 vrs is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Goldie Freeman Rose McCollough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Gladys Freeman/wife 1109 Morningside Dr., Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven 4/16/2012 Silver Spring, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signature Funeral Service License 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ cardy opulmo nary disease or condition resulting in death) Medical Examiner mration Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine cirebro vas ulo raccident cian. physician Physician/Medical the IF FEMALE: asn 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ŏ Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Combleted 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital ပ 1 Yes 2 No Other: Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Records, Division of Vital To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After filled in by Médical within 2 To the I 200 100

> State APR 13 Registrar

29a. Certifie (Check

only one

Name and addre

3

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Suburban hospita Nadar ND

of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D70241

29d. Date signed (Month, Day, Year)

8600 Old Georgetwr

4/12/2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#20bperFH, 4/18/12; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day V . . Helen Foerst 2012 8:55 P M 9 Medical <u>April</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 500 Auburn Avenue Rockville Montgomery Social Security Number If Unde 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Months Hours 154-18-9159 90 New Jersey **Director** 1 □ M 2 🗓 F Dec. 4,1921 Usual Residence of Decede show at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Montgomery Rockville 1 🗶 Yes 2 🗌 No 10e. Street and Number ö 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? by Funeral 1500 Auburn Avenue 20850 United States ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married X Yes 2 No WW II Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Public Health College (1-4 or 5+) Elementary/Secondary (0-12) d Mental Hygiene. marked other tha Service Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Foerst traumatic Anna Fitzpatrick and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Robert J. Taborn (Nephew) 43 Barberry Drive, Ocean , NJ 07712 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date Unik - 20c. Location - City or Town, State . _ Metropolitan
Cremator 1 Burial 2 X Cremation 3 Removal from State 0 Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) rematory April 13, 2012 | Alexandria, VA 22. Name and Address of Facility Home, 10 East Deer Park Drive, 21. Signature of Funeral Servi M00689 Gaithersburg , MD 20877 23a. har the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Metastatic Squamous Cell Medical resulting in death) Examiner Waldenstrom Macroglobulinemia Sequentially list conditions, Examine cause. Enter Underlying death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year the Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law cate has autopsy certificate 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗶 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify After this funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident injury Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗔 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar ore

31. Date filed (Month) Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

2

10

Corey Allan Carter M.D., 8901 Wisconsin Avenue, Bethesda, MD 20889

3 Registrar's Signature

VA 0101236858

29d. Date signed (Month, Day, Year)

April 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year RONALD FOWLER 1709 Medical ADIL 7.012 acility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PENINSULA RPOWNIL POICAL Cento SA415by1 1Comics 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Days Hours 152-54-9712 Months **Director** 1 **X** M 2 □ F BEARDSTOWN, 56 OCT 27, 1955 Usual Residence of Dece 28a-f show 10b. County at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits notified DELAWARE SUSSEX COUNTY LAUREL 1 Yes 2 No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 6056 OLD SHARPTOWN ROAD 19956 UNITED STATES 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Force ō þ Black, White, etc. 1 X Never Married 2 Married Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Yes. Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ the TRUSS FABRICATOR CONSTRUCTION 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CLIFFORD JAKE FOWLER ESTHER ADELAIDE ERNEST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra DONALD FOWLER (BROTHER) 6056 OLD SHARPTOWN RD., LAUREL, DE 19956 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 ဳ Cremation 3 🗌 Removal from State crematory or other place FIRST ST. CREM. CTR. APR.10,2012 MILLSBORO, DE 4 ☐ Donation 5 ☐ Other (Specify) Signat of Properal ervice Licensee 22. Name and Address of Facility 19966 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE MO 1361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury Due to (or as a consequence of) Exami that the death certificate be executed and burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA

Division of Vital Records, P.O. Box 68760

After this certificate has To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director, After this certifies funeral filled in by the

> BAIBARS M.O.

5 Pending

Investigation

determined

6 Could not be

27. Manner of Death

1 Natural

☐ Accident☐ Suicide

29b. Signature and title of certifier

4 Homicide

29a. Certifier

(Check only one

Certificate:

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28c. Injury at work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

4-13-2012

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROIL 100 6

28a. Date of injury (Month, Day, Year)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

meera

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elmer C. Fuss April 6, 2012 1:46 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1307 Pinewood Drive Frederick Frederick Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 216-22-9690 **Director** 1 🛛 M 2 🗆 F 83 May 10, 1928 Maryland Usual Residence of Decedent 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 1307 Pinewood Drive United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian by 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 2 🙀 No 1 Yes 2 No Specify: 3 - Widowed 4 - Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automobile Repair 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Belle Martin Elmer Fuss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 Pinewood Dr., Frederick, MD 21701 Donna Fuss / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ApriPate 10, Important: If it any injury or o once. 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Restnayen Frederick, Maryland 2012 4 Donation 5 Other (Specify) Memorial Gardens Signature of uneral So vice Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. P. 1. Enter e disease shock, or he nt failure. L Immediate C v. se (Final disease or condition resulting in death) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Interval Between Onset and Death Physician/ Aturosclarotic Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-trar attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, Completed 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital Other: မ 4 Nursing Home 5 X Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completely filled in by the funeral Manner of Death e Hospital or Attending Pi 124 hours after death. e Funeral Director: After th Certificate: 28a. Date of injury 28b. Time of 28c. Injury at Natural (Month, Day, Year) 5 Pending work 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one? 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0611 and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1564 Opossumtown Pike, Frederick, MD 21701 Melissa Asuncion, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Raymond **Tyrone** Fantroy April 7 12:55 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Fort Washington Medical Center Fort Washington Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 □ F Days Hours 577-62-8224 65 March 20,1947 Washington, D.C **Director** Usual Residence of Decedent 10a. State ms 23a or 28a-f shormust be notified at 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12612 LaGrange Court 20744 United States items (12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ♠ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ö þ 1 Never Married 2 Married Black, White, etc. 3altimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: **Black** Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry the M nentary/Seconday (0-12) College (1-4 or 5+) 12th grade Customers Service Attendant event, th Home Depot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of 27 is marked or traumatic ever ည William McKinley Fantroy Bernice Dorothy **Epps** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 27 Gloria James Fantroy (Wife) 12612 LaGrange Court; Fort Washington, Maryland 20744 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 ± 5 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland 21. Signature of Faneral Service License 22. Name and Address of Facility ${f R.N.}$ Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ANCER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir inding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has page 2 autopsy performed? Yes 2 No prior to completion of cause of death? this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MV

nderim

the Hospital

8507

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1741182

UYON HII RI # IUZ FT. WA

2791		Please Type or Print in Black Indelible	Ink. Ensure All Co	pies Are Leg	ible.
am Marsha	ll Gi	inder State of Maryland / Department	of Health and Menta	l Hygiene	2012 1341
Dl		1- For State Certificate Registrar 1. Decedent's Name (First, Middle, Last)	of Death		j. No.
Physici lical Exam			To an a	April 9, 201	Day Year 1131 hrs
		Peninsula Regional Medical Center	4b. City, Town, or Location of E Salisbury	De <i>a</i> th	4c. County of Death Wicomico
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or
Director		220-58-8917 1\(\text{M}\) 2\(\text{F}\) 59	rs. Months Days Hours	June 15	Forèign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot	otion		
	_	Too. Oily, Town of Edit	ation		10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	Director	MD Montgomery Olney 10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
the Man 2		17953 Dumfries Circle 2	0832		USA
within 72 hours after death with the Maryland jene. ser than "natural", or items 23a nr 28s-f shu Medical Examiner must be notified at once.	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No-	14. Race - American Indian, Black,
er deat	Fun	1 X Never Married 2 Married 1 X Yes 2 No 1 Yes, 2 No 2 N	_	uerto Ricari, etc.)	White, etc.
urs aft tural"	d b		Yes 2 X No specify: ent's Usual Occupation (Give kind	d of work done	Specify:White 16b. Kind of Business/Industry
thin 72 hours after te. than "natural", edical Examiner	ete		most of working life. DO NOT use	e retired)	ios. Faile of Eddinoss/madstry
iled within 72 ho Hygiene. I uther than "m the Medical Ex	ompleted		ject Manager		Air Conditioning
E E E	BeC	17. Father's Name (First, Middle, Last) Edward Marshall Grinder		lame (First, Middle, Ma	aiden Surname)
ould be filed with a Mental Hygiene I marked other ic cvent, the Me	To B			t R. Hall	er, City or Town, State, Zip Code)
Pages 1 and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,			3 Dumfries Circ		
s l and f Heal If iten		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or	osition (Name of cemetery,	Date :	20c. Location - City or Town, State
Page ment c		4 Donation 5 Other Specify: Metropoli	tan Crematory	April 12, 2012	Alexandria, VA
permit. Pages I and 2 shoul Department of Health and IN Important: If item 27 is m injury or other traumatic		21. Signature of Funeral Servica Licensee	Name and Address of Facility	ns Funeral	Home Inc.
nysician		23a. Pan I. Enter the disease, or complications that caused the death. Do not ente	the mode of dving, such as cardi	IVd. W, Si	Iver Spring, MD 20901 t, shock, or heart Approximate Interval
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries	, •	,	Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of);			
٨	Examiner	cause. Enter Underlying Cause			
and and transit		events resulting in death) Last Due to (or as a consequence of):			
	Ea	d. UNPENDED AMENDED			
eath certificate be ex attending physician for use as the burial	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
certifi nding ise as t	ian	Pregnant at time of death	etal death 3 Ectopic pre	egnancy	Month Day Year
e death the atte ed for u	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
hat the ed by t letache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
equires that en signed ald be deta					2 No 3 Probably 4 Unknown
aw req	Plet			24a. Was an autopsy	 Were autopsy findings available prior to completion of cause of
The licate h	Completed	_		performe	ed? death? No 1 🗸 Yes 2 No
ician: s certif rector,	Be	25. Was case referred to medical examiner? 1 ✓ Ves 2 No. Hospital: 1 Inpatient 2 ✓ ER/Outpatien	26.Place of Death (Che		
g Phys fer thi	2	27. Manner of Death 28a. Date of Injury 28b. Time of		rsing Home 5 Re	viniury occurred
death. ctor: Ay	ation	1 Natural 5 Pending Apr 9, 2012 Pending 1051 hrs	1 Yes 2 ✔ No	Subject driver	lost control of car that flipped and
ipital or At ours after d ieral Direct filled in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str (Specify) Local Street	eet, factory, office building, etc.	or Town, State	eet and Number or Rural Route Number, City e) Bound near Bent Pine Road, Willards, M
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurrence 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, ation, in my opinion, death occurre	and due to the cause(s	s) and manner as stated. d place, and due to the cause(s)
0	M	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
1011		Outer Hatte Held 18	O.C.M.E.	<i>F</i>	April 10, 2012
		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 \	V. Baltimore Street, Baltii	more. MD 21223	
	310	31. Date filed (Month, Day, Year) 32. Registrar's Signature	2.2 2.000, 20111		

Registrar

DOME

amend 5,17,per fh,g927 5-9-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland / Depa	artment of He	ealth and I	Mental Hyg	giene	
			Registrar		Cer	tificate of D	eath		Reg. No. 201	2 1344
	Physicia Medi		1. Decedent's Name (First, Middle, Las Tho	mas Joseph	r Gletner			2. Date of Dea Month April	Day Year 11 201	3. Time of Death 1455 M
	Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or L	ocation of Death	IApuu	4c. County of De	
***			Tate Hospi				nthicum		Anne	Arundel
	Funeral Director		5. Social Security Number 6. Se 578 – 30 – 4177	ex DXLM 2 □ F 7. Ago	e (In yrs. last birthday) § 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08/05/	Year) 8 9. B	irthplace (State or Foreign ountry) Maryland
	D wo	L	Usual Residence of Decedent 10a, State 10b, County					1 00/00/	1,20	
	ırylan I-f sh ied a	cto			10c. City, Town or Loc					10d. Inside City Limits
	or 28	Director	Maryland Anne A	rundel		A 10f. Zip Code	nnapolis		40 0''' (111 1	1 Yes 2 X No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	933 Riverse	dge Circle	2		21401		10g. Citizen of What C	.S.A.
	r iter		11. Marital Status	12. Was Decedent E Armed Forces?	lf	Vas Decedent of Hisp Yes, specify Cuban,	oanic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
920	s after ral", o Exam	ed by	1 Never Married 2 🕱 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 【☐ If Yes, Give Year or Dates.	No 1	☐ Yes 2X No	Specify:		Specify:	White
5-0	hour "natur dical	plete	15. Decedent's Ec (Specify only highest gra	ducation	16a. Deced	ent's Usual Occupati	on		16b. Kind of Busines	
121	thin 73	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	(+) life. DO	rind of work done dur DNOT use retired) Dller of Geo	rgetown	ing	Неа	lthcare
d 2	lled wi I Hygie other ent, t	Be	17. Father's Name (First, Middle, Last)	James D. (Univ	<u>ersity Hospi</u>	tal	e (First, Middle, N		
Baltimore, Maryland 21215-0036	2 should be filed th and Mental Hy 27 is marked oth traumatic event	P	Jam		Gletner				na Brangle	
Mar	2 shou th and ?7 is m traum		19a. Informant's Name/Relationship (Ty						City or Town, State, Z	
e,	of Healt of Healt fitem 2 r other		Guelda Gletner - 20a. Method of Disposition	- Spouse	20b. Place of Dispos				olis, Mary	
<u>m</u>	Page 1 ment of I ant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		**	atory or other place) feaven_Cem			Silver Spr	
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licens	() +/	401564 22.	Name and Address	of Facility Hin	es-Rina	ldi Funera	l Home, Inc.
ė			23a. Part 1. Enter the disease, or comp	lications that caused						ng, MD 20904
	hysician/		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line	L'Failure	, , , , , , , , , , , , , , , , , , ,		or roopilatory arro		Approximate Interval Between Opset and Death
	Medical Examiner		disease or condition resulting in death)		consequence of):					Days
	Lxammer	e	Sequentially list conditions,	υ.	tension					Years
	ted T	Examiner	If any, leading to immediate cause. Enter University Cause (Disease or iinjury	Due to (or as a	consequence of):					
	v requires that the death certificate be executed to be secuted to been signed by the attending physician and should be detached for use as the burial the states and the burial the states are the states	al Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of):	 -				
760	cate be physic the bu	edical		d	<u> </u>					
89	certific inding use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	alivery
ã	death ne atte ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	law requires that the nas been signed by the 2 should be detach		Part II. Other significant conditions co		at not resulting in the un	derlying cause given	in Part I.	23e Did tob	pacco use contribute to	the cause of dooth?
S, F	uires the naigner of signeral	ed by					- 15.			Probably 4 🔀 Unknown
Vital Records,	aw req as bee 2 shor	Completed						24a. Was ar		itopsy findings available completion of cause of
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<u>Ital</u>	sician certifi irector	m	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\overline{\mathbb{X}} \) No	lospital:		Other:	of Death (Check			
ŏ	ig Phy er this neral d	te: To	27. Manner of Death	28a. Date of injury		28c. Injury at			nce 6 X Other (Spec w injury occurred	city) Hospice
<u>o</u>	tendin leath. or: Aft the fur	Certificate:	1 Natural 5 ☐ Pending Description Suicide 6 ☐ Could not be	(Month, Day,	Year) injury	work? M 1 ☐ Yes	s 2 🗆 No			
Division of	lor At after c Direct Jin by	Cert	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stree (Specify)	et, factory, office		28f. Location (Str City or Town,	eet and Number or Ru State)	ral Route Number,
_	lospita t hours uneral ed fillec	Medical	29a. Certifier 1 1 Certifying Physi (Check 2 Medical Examin	cian: To the best of n	ny knowledge, death oc	cured at the time, da	ate and place, and	d due to the caus	e(s) and manner as sta	ated.
	violine Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Me	only one) 3 Certifying Nurse	Practioner: To the b	est of my knowledge, de	eath occurred at the tir	ne, date and place	e, and due to the o	cause(s) and manner as	
	FSFEU		midfo	& Dwan	w		D21438	29	ed. Date signed (Monti April 11,	
		ŀ	30. Name and address of person who co	•		nt)				
	Stat		Michael J. LaPento 31. Date filed (Month, Day, Year)				Annapol	is, Mary	pland 2140	1
	Registra	_	APR 13 2012	Renda	's Signature					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please				ndelible In			-	_	ible.	
		For State		State o	f Marylan		artment of H		d Mental				10114
		Registrar 1. Decedent's Name (File	rst. Middle, I a.	R <i>t</i>)		Cer	tificate of L	Death	2 Date	Reg. I	No. 2 ()	12	13447
Physicia Medic		Warren Sp		′					180		Day 20)Year	3. Time of Death / S ! 24 M
Examir		4a. Facility Name (if not			ber)		4b. City, Town, o			1	4c. County	of Death	
Francis		Meritus M. 5. Social Security Numb			7. Age (In yrs. la	act hirthday)	Hager If Under 1 Year	stown	fre 0 Data		Washi		County
Funeral Director		007-22-957		M 2 □ F	84	Yrs.	Months Days		in. (Mon	of Birth th, Day, Year il 3,1	928	Count	
ld sow	L	Usual Residence of De	ecedent b. County			y, Town or Loc	ation		Apr	11 2,1	.920		ine
larylan 3a-f sh ified a	ecto	Maryland W	,	on Coun		gerstow						10	0d. Inside City Limits 1 ☐ Yes 2 X No
the Manager 28	ij	10e. Street and Number					10f. Zip Code			10g.	Citizen of W	/hat Count	
th with ms 23:	Funeral Director	14014 Mar	sh Pike				21742				U.S.	Α.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 3 Widowed 4		Armed For	dent Ever in U.S ces? 2	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	an, Mexican, Pu	(Specify Yes o erto Rican, etc	or No- c.)	Black	e - America k, White, e Whit	etc.
2 hour "natu	plete		5. Decedent's E	ducation	1933		ent's Usual Occup		vorking	16b.	Kind of Bu	siness/Ind	dustry
ithin 7 ene. r than	Completed	Elementary/Seconda	, , ,	College (1-	4 or 5+)	life. DO	NOT use retired)		VOIMING	Pı	rivate	e Car	. e
illed wall Hygial Hygial I other	Be	17. Father's Name (First,	Middle, Last)		3-314- ·			18. Mother's N	Name (First, M				
Ments Ments larked	٦	Edward L	. Godin	g				Ethel	. DeMer	ritt			
2 shouth and the shou		19a. Informant's Name/			اه مع		g Address (Street a			-		ate, Zip Ci	ode)
f Healf f Healf item 2 other		N. Kenneth 20a. Method of Disposit	ion		20b. P	lace of Dispos	xine Tra		IleId,		Location -	City or To	wn State
Page nent or ant: If ant: If ary or		1 ☐ Burial 2 [XC 4 ☐ Donation 5 ☐	remation 3 C	Removal from (State Ci	emetery, crem	natory or other place rg Cremat	e) Lory 4-1			ithsb	-	
ermit. epartn nporta ny inju		21. Signature of Funeral	Service Licens	see	1- /	22.	Name and Addres	ss of Facility	Douglas	s A. F			
0 □ = a o		23a. Part 1. Enter the d	2 Jaff	none	Sut	1.	<u>331 Easte</u>	<u>ern B</u> lvo	d. Nort	h Hag	ersto	wn, N	MD 21742
Physician/		shock, or heart fail	lure. List only o	ne cause on eac	:h line.						t	- 1	Approximate Interval Between Onset and Death
Medical		disease or condition resulting in death)		a. Due to (c	r as a consequ	ence of):	e Trical	FICHALL	4 6 %	000		-	
Examiner	J.	Sequentially list condition	ons,	b. Hy	ras a consequ	~5:01							
ed	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury		Due to (c	or as a consequ		dnay	Dicea	CL				
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ertifica ding p	/Me	IF FEMALE:		23c. If yes, outc	ome of pregnar	ncv							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bi	Physician/Medical	23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	ths?	1 Live B	irth 2 🗌 Fetal ant at time of d	I death 3 🗌	Ectopic pregnanc Other (specify)	У			23d. Date Mon	e of deliver oth [ry Day Year
s that gned k	by	Part II. Other significan				_		en in Part 1.					e cause of death?
equire een si hould	eted		4 5 246	Virgen(W 1-	2018	CNI		-	1 Yes	2 □ No :	3 Proba	ably 4 Hinknown
e law r has b ge 2 s	Completed									Was an autopsy performed?	pr	ere autops rior to com eath?	sy findings available npletion of cause of
an: Th tificate tor, pa	Be Co	25. Was case referred to	medical				26 Pla	ace of Death (C/		Yes 2		☐ Yes 2	2 No
hysici nis cer il direc	To B	examiner? 1 Yes 2 No	r	Hospital: 1 □ Ir	npatient 2	ER/Outpatient	Otha	or.	Home 5		6 🗌 Other	(Specify)	
Jing P	ate:		Pending		f injury , <i>Day, Year)</i>	28b. Time of injury	28c. Injury work	?	28d. Desc	ribe how inju	ury occurred	Ė	
Attenc r death ector: .	Certificate	2 Accident 3 Suicide 6 [4 Homicide	Investigation Could not be determined	<u> </u>	of Injury - At hor	me, farm, stre	M 1 L	Yes 2 No	28f Locat	ion (Street a	nd Number	or Rural E	Route Number,
tal or, rs afte al Dire		4 🗀 Florificide	determined		g, etc. (Specify)					or Town, Stat		OF FIGURE	route Number,
Hospi 24 hou Funer stely fil	Medical	(Check 2 □ N	viedical Exami	ner: On the basis	of examination	and/or investi-	ccurred at the time gation, in my opinio	 n. death occurre 	d at the time.	date and place	e and due t	to the caus	se(s) and manner stated
To the vithin to the complex c	— r	only one) 3 L C	Sertifying Nurs	e Practitioner:	To the best of m	y knowledge,	death occurred at the	ne time, date and	d place, and du	e to the caus	se(s) and ma	anner as sta	ated.
- > - 0		1 Fair	1 m	hand				039	6	€	4/42	- 112	-,,
1 = 11		30. Name and address o		- 0		23a) (Type, Pr			Jet	Has	cors?	Toul	`
W-541		31. Date filed (Month, Da		- V	gistrar's Signatu	Ire		· · ·			J WL	21	1740
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	/ Departr	ment of H	ealth and	d Mental Hy	giene			
			1 - State Registrar	Certifi	cate of D	eath		Reg. No. 2	112	1344	C
	Physicia									3. Time of Death 17:55P	М
Asses	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b.	. City, Town, or I	Location of De	ath	4c. County			
-			3523 SOUTH MOUNTAIN ROAD		KNOXVI				DERI		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Under 1 Year onths Days	If Under 24 H Hours Mi		y, Year)	9. Birthp Count	lace (State or Foreig try) PA	n
	ind show at	2	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Locatio	n				11	0d. Inside City Limit	S
	Maryland 28a-f show otified at	Director	MD FREDERICK KNO	XVILLE	Ξ					1 🗌 Yes 2 🛂	NO
	with the N 23a or 2 st be no	eral Di	10e. Street and Number 3523 SOUTH MOUNTAIN ROAD	10	0f. Zip Code 217!	58		10g. Citizen of W		try?	
ပ္	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	If Yes	s, specify Cuban	, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Blac	e - America k, White, e	etc.	
21215-0036	nours afti natural", ical Exar	Completed by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	6a. Decedent's	s Usual Occupa			Specify:	WHI'		
1215	within 72 h rgiene. ner than "n t, the Medi	Compl	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NO	of work done du OT use retired) EMPLOY:	Ü	vorking	HOUSE			
Maryland 2	ntal Hygi ed other: event, 1	To Be	17. Father's Name (First, Middle, Last)	SELL I		18. Mother's N	lame (First, Middle,	Maiden Surname			
ž	should be file and Mental H 7 is marked o raumatic eve	ľ	DAVID CLAIR DIEHL 19a. Informant's Name/Relationship (Type, Print)	19h Mailino Ar	ddress (Street ar		Rural Route Numbe	·	tate. Zip C	ode) 21758	
	and 2 sh Health ar tem 27 is		EARL GRAVLEY, JR. / SON	3529 8	SOUTH		AIN RD.,	KNOXV	ILLE	, MĎ''	
Baltimore,	Page 1 ament of Hant of Hant: If ite		1 Puriol 2 Cromation 3 Permoval from State Ceme	e of Disposition etery, cremator FFER (n (Name of ry or other place CREMAT	ORY 04	Date 4/11/201	20c. Location -	-	ICK, MD	
Balt	permit. Page Department Important: any injury o		21. Signature of Juneral Service Licensee		me and Address			O. BOX			
			23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.		e mode of dying	, such as card	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed the hours and great death. Fuherial Director, Affer this certificate has been signed by the affending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗌 Ect	topic pregnancy her (specify)	/		23d. Dat Mor	e of delive	ery Day Year	
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Division of Vital Records,	ding Physician: The law r h. After this certificate has b funeral director, page 2 s	Completed by					24a. Was autoj perfo	osy pormed?		npletion of cause of	
<u>e</u>	cian: ertifica ector,	Be (25. Was case referred to medical examiner?			ce of Death (C	heck only one)				
of Vi	Physic r this cerral dire	은	1	b. Time of	28c. Injury	4 □ Nursing	Home 5 Hesio	dence 6 Othe			
ion	tending eath. or: Afte the fune	ificate	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be			res 2 ☐ No					
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Certificate:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, f	factory, office		28f. Location (\$ City or Tov	Street and Numbe m, State)	r or Rural	Route Number,	
	e Hospii 1 24 hou e Funer bletely fill	Nedica	29a. Certifier (Check only one) 1	nd/or investigation	on, in my opinior	n, death occurre	ed at the time, date a	and place, and due	to the cau	ise(s) and manner sta	ated.
	To the comp	-	29b. Signature and title of certifier		29c. License			29d. Date signed			
			1estalidet 7	MO	Do	054	940	04	:110	12013	
	3		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print)		Para	+mano (s	Fern	ERIC	K. MD	
	Sta Registr		31. Date filed (Month, Day, Year) 2012 32. Registrar's Signature	h. pa	Med		.,	, , , , , ,			

State of Maryland / Department of Health and Mental Hygiene Anastacio Mendez Garcia

2012 13450

		1- For State Registrar			Certific		Death				Reg. N	0.		
Physicia		Decedent's Name (First, Middle	liddle,Last) Anastacio A. Garcia 2. Date of Death 3. Time of D					3. Time of Death						
ledical Exami		Anastacio Men	ndez Garcia April 16, 2012 1-					1415 hrs						
		4a. Facility Name (if not institution	n, give street and r	, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
		1607 Parkridge Circle					Crofton					Anne Ar	undel	
Funeral		5. Social Security Number	6. Sex	7. Age (I	n yrs. last bir	thday)	If Under 1 \		Inder 24Hr	s. 8. Date of	Birth (M	M/DD/YYYY		hplace (State or
Director		220-79-7665	1 X M 2 F		44	Yrs.	Months D	ays H	ours Mi	04/	15/1	968	Foreig Cou	n untry) Mexico
		Usual Residence of Decedent	· <u> </u>						— <u></u>	0 17	20/ 2	, , ,		
ģ		10a. State 10b. County		10	c. City, Town	or Location	n						$\overline{}$	10d. Inside City Limits
ind show :		Maryland Anne A	rundel		Croft	on							ı	1 Yes 2 No
rylan t onc	횽	10e. Street and Number	- under				10f. Zip Cod	A			10a. C	itizen of Wh	at Cour	itry?
or 28	ē			"				•						,.
th the	Funeral Director	1607 Parkridge				1	21114					xico		
th wi	Jer.	11. Marital Status 1 Never Married 2 X Ma	12. Was De	ecedent Eve Forces?	er in U.S.					pecify Yes or Rican, etc.)	No-	14. Race White		can Indian, Black,
or it	교		1 Yes	2 X	No	. [\$7]			M				His	panic
s afte	ã		orced If Yes, Give Your Dates:		1-15 140-		Yes 2				Lion	Specify:		
hour	8	15. Decedent's Education (Spec			eted) 16a.		s Usual Occu st of working				160	. Kind of Bu	siness/ii	naustry
n 72	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	In	vento	ry Man	ager			R	etai1		
Mer the	E	17. Father's Name (First, Middle,						1 40 14-)	e (First, Midd				
filed Hyge			Last)					1	lores			endez		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than it event, the Medical	Be	Jose Garcia 19a. Informant's Name/Relationsh	nin (Type Print)		10	h Mailing	Address /S			Rural Route I			- State	Zin Codo)
MD 2 d 2 shoul Ith and IA n 27 is n	유	Bertha Garcia								243, C				
md 2 salth cm 2 raum		20a. Method of Disposition	WIIC				ion (Name of			Date		Location -		
of Her		1 Burial 2 X Cremation	3 Removal	from State	crema	tory or othe	er place)						•	
Pag Pag ment tant:		4 Donation 5 Other Sp	ecify:		Kalas		matory			19/201	2 E	dgewa	ter,	MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatie event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	icensee				me and Addr		00					al Home,P.A
E. E. D. 8.		The IV.	2											MD 21037
Physician	-1	22.1 Part I. Enter the disease, or failure. List only one cause		caused the	death. Do n	ot enter the	e mode of dyi	ng, such a	as cardiac	or respiratory	arrest, s	hock, or hea	ırt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a.Cardia	c Arr	hythmi	a								Death
_xaiiiiiei		or condition resulting in death)	Due to (or as	a consequ	ence of):			-01						,
	L	Sequentially list conditions,	b <u>Dilate</u>			ular	Hypert	roph	y				_	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	ence of):									
	am	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):									
ecuted and - transit		CYCING FOODINING IN GOODING EAST	d.											
760, icate be executed physician and the burial - transi	/Medical	X UNPENDED	X AMENDED	# 1,2	3a-b,2	7, pe	me,g	927 5	-7-12	2 sm				
60, ate be hysici	₽	IF FEMALE:	23c. If ves	outcome o	of pregnancy						2	3d. Date of	delivery	
		23b. Was decedent pregnant in the past 12 months?				2 Feta	l death	3 Ect	opic pregn	ancy	- 1	Month		ay Year
Sox 68' leath certifi e attending for use as t	<u>:</u>			nant at tim			er (Specify)							
e deal	Physiciar		nown 9 Unkr											
P.O. es that the igned by be detach	by P	Part II. Other significant conditi	ons contributing	to death bu	it not resultin	g in the un	derlying caus	e given ir	Part I.				-	he cause of death?
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as										1 📗	Yes 2	No 3	_ Proba	ably 4 🗹 Unknown
of Vital Records, ag Physician: The law require. There this certificate has been sinneral director, page 2 should be	Completed									24a. W	as an topsy			opsy findings available ompletion of cause of
e has	튑									ре	rformed?	d	eath?	
		25. Was case referred to medical		_			26 DI	ace of De	ath (Check		s 2	NO 1	√ Yes	2 No
ician: s certifi rector.	Be	examiner?	Hospital:	Inpatient	2 EB/0	utpatient		Other		ng Home 5	Boois	dence 6	Othor	Sanna
f Vi Physi er this	٤	1 Yes 2 No	[28a Date	e of Injury		Time of Inj		njury at W				njury occurre		3Celle
ding Ph	<u></u>	1 X Natural 5 Pend	(Mont	th, Day, Yaar)	200.	Time of my	-	Yes 2		200. Descri	JO HOW II	ijury occurre	·u	
SiOr Attend death cctor:	cati		tigation		44.5					001.1				15 1 1 1 0
Division pital or Attendii ours after death.	Certification:		not be	100	- At nome, is	arm, street	, factory, offic	e bullaing	, etc.		n (Street n, State)	and Numbe	r or Rur	al Route Number, City
E 2 2 E	3	4 Homicide	(Openin)							L				
n 24 hor Fun	Sa	(Check only Certifying Pil	ysician: To the be niner:On the basis	-	-									
To the within 2 To the complet	Medical	2	and manner		ation and/or i					at the time, de				
	2	29b. Signature and title of certifier	1000					ense numl	Del					th, Day, Year)
		Carol	Hall	du	_		0.0	C.M.E.			Ap	ril 17, 20	12	
	Ì	30. Name and address of person										·		
			sistant Medica	Examin	er 900 \	W. Balti	more Stree	et, Balti	more, N	D 21223				
	ate	31. Date filed (Month, Day Year)	0 0040 32. F	gistrar's S	Signature	1	N. J							
Regist	rar	APR 3	U ZUIZI /	busca	J 13.	100	V.							

OCME

			State	epartment of Health and Certificate of Death		2012	13451
П	Physicia	an/	1. Decedent's Name (First, Middle, Last) Orn Haw	Sertificate of Beatif	2. Date of Death		3. Time of Death
N. Say	Medi Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	April	71 2012	12:15 am
-	LAGIIII	ici	2007 Ballows Way	Silver Sp		4c. County of Death	gomery
24	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	lay) If Under 1 Year If Under 24 Hr	rs. 8. Date of Birth	9. Birth	place (State or Foreign
	Director	ı	577-04-9952 1□M212F 93 YI		n. (Month, Day, Y	,	ambodia
	ind show at	i	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	r Location	01/01/1		10d. Inside City Limits
	Maryla 28a-f	Funeral Director	Maryland Montgomery	Silver Si	pring		1 ☐ Yes 2 💢 No
	a or 2 be no		10e. Street and Number	10f. Zip Code		ng. Citizen of What Cou	ntry?
	th with ms 23 must	ner	2007 Ballows Way	20906		u.s	.A.
10	r deal	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ □ Sec 2 ☑ No.	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
036	s afte ral", c Exan		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates.	1 ☐ Yes 2 ื No Specify:		Specify:	Asian
2-0	hour "natu dical	Completed	15. Decedent's Education 16a. D	ecedent's Usual Occupation	,. 1	6b. Kind of Business/In	
121	thin 72 ine. than	mo		ive kind of work done during most of wo e. DO NOT use retired)	orking		
0	ed wil Hygie other ent, tt	Be C	17. Father's Name (First, Middle, Last)	Homemaker			n Home
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	은	Pong Hauv	18. Mother's Na	ame (First, Middle, Ma Touc ,	h Lao	
lary	should and M is ma auma		19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Ri			Code)
%	and 2 fealth im 27 her tr		Horn Lok - Daughter 200	17 Ballows Way, Sil			
JOL	mt of h		1 X Burial 2 Cremation 3 Removal from State cemetery,	isposition (Name of crematory or other place)		0c. Location - City or To	· ·
量	artmen artmen ortani injury		4 Donation 5 Other (Specify) Gate 0 21. Signature of Funeral Service Licensee	6 Heaven Cem. 04/	16/2012 SA	ilver Sprin	g, Maryland
Ba	permi Depar Impo any ir		MOIS24	22. Name and Address of Facility Hu 11800 New Hampshir	rnes-krnal ro Avo Si	al Funeral	Home, Inc. $3MD$ 20904
Т			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate
~-{	Physician/	1	Immediate Cause (Final disease or condition Liver Cance) fi			Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):				
		er	Sequentially list conditions, b.				
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	an and		that initiated events resulting in death) Last c. Due to (or as a consequence of):				
09	law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burlattacsit	dical	d				
687	eath certificat attending ph for use as th	/Me	IF FEMALE:				
Box (ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Use 2 By No. 23c. If yes, outcome of pregnancy 1 Use Birth 2 Felal death 4 Pregnant at time of death			23d. Date of delive	·
m ·	requires that the des been signed by the a should be detached	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		William	D <i>a</i> y Ye <i>a</i> r
P.O.	ned b	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
ds,	quires en sig ould b				1 🗆 Yes	2 X No 3 □ Prob	ably 4 🗆 Unknown
Vital Records,	raw re las be e 2 sh	Completed			24a. Was an autopsy	24b. Were autop	sy findings available
Ψ̈́	icate h				performe	d? death?	
/Ita	sicrar certif lirecto	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No Hospital:	26. Place of Death (Che			
to '	g rny er this neral o	e: 10	27. Manner of Death 28a. Date of injury 28b. Time	e of 28c. Injury at	Home 5 X Residenc 28d. Describe how i	e 6 Other (Specify)	
0	endin eath. or: Afti	ficat	1 X Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation	y work? M 1 ☐ Yes 2 ☐ No	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	mary document	
Division of	fter de pirecte in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural I	Route Number,
5	ours a ours a leral C	edical (29a. Certifier 1 2 Certifying Physician: To the best of my knowledge, dear	AL		,	
2	to use Topping or Autending Prysician: The law, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medi	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, dea 2 ★ Medical Examiner: On the basis of examination and/or in 3 ★ Certifying Nurse Practitioner: To the best of my knowled	estigation in my opinion, death occurred :	at the time date and n	lace and due to the equi	14-4
4			29b. Signature and title of certifier	29c. License number		. Date signed (Month, D	
	2		1 Km - Til agi No. O.	130399	Î	4/12/19	
			30. Name and address of person who completed cause of death (Item 23a) (Typ		Dating Ha	h. 10 a 1 0 0 0 0	14
	State	e_	Kim Pang, M.D., 12113 New Hampshir 31. Date filed (Month, Day, Year) APR 13 2012		sprung, ma	ryxana 2090	4
	Registra	r	APR 13 2012 (Month, Day, Year)	Name of the second			

		1 - State State of Maryland / Department / Departmen	artment of Health and N		201	2 345
Physicia		Decedent's Name (First, Middle, Last) Zelda Arlene HOOVER	in data di Dadin	Date of Death Month		3. Time of Death
Medic Examin		4a. Facility Name (if not institution, give street and number) Meritus Medical Center	4b. City, Town, or Location of Death Hagerstown	Apcil	4c. County of Dea	th
Funeral Director		5. Social Security Number 215-18-1988 6. Sex 1 M 2 🖾 F 88 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Oct. 14,	(ear) Co	thplace (State or Foreign ountry) ryland
ryiand -f show ied at	ctor	10a. State 10b. County 10c. City, Town or Loc			<u> </u>	10d. Inside City Limits
the Ma or 28a e notif	Dire	10e. Street and Number	rstown 10f. Zip Code	10	ng. Citizen of What Co	1 X Yes 2 □ No
th with ms 23a must b	Funeral Director	1411 West Church Street	21740		USA	
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	Never Married 2 Married 1 Yes 2 K No	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 ★ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	Completed	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of worki ind NOT use retired)	ng 1	6b. Kind of Business	
d 21;	Be Co	Elementary/Secondary (0-12) College (1-4 or 5+) CO-O 17. Father's Name (First, Middle, Last)	wner		lectric s	ervice
Maryland 21215 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r traumatic event, the Med	To E	Melvin G. Ridge	18. Mother's Name Mae Ann		iden Surname)	
Mar.			Address (Street and Number or Rura W. Church Street			
Baltimore, Dermit. Page 1 and Department of Heal mportant: If item: any injury or other		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Dispos cemetery, crem.		Date 2	0c. Location - City or	
Baltimol permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility MIN. 5 E. Wilson Blvd.	NICH FUN	ERAL HOME	
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	the mode of dying, such as cardiac or		,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				YEM
uted d ansit	Examiner	If any leading to immediate Ducito (or as a consequence or): cause. Enter Underlying Cause (Disease or injury Lift Ranks: ARRA	L PARKILLATION			YEARY
be ez siciar buria	dical Ex	that initiated events resulting in death) Last Due to (or as a consequence of):				
certificate anding physuse as the	/Med	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy				
box or death cent the attent ched for us	Physician/Me	in the past 12 months? 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	_	23d. Date of del Month	ivery Day Year
J. the see	م ا	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to	the cause of death?
Hecords, The law requires cate has been sig	Completed			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
cian: T	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	1 Yes 2 only one)	No 1 L Yes	2 🗔 No
or Vital ng Physician: ter this certific	e: 10	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at 2	ne 5 Residence 8d. Describe how	ce 6 Other (Speci	ify)
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UIVISION OT VITAI HECONDS, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director, After this certificate has been sign completely filled in by the funeral director, page 2 should be	Med	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death ocolonly one) 1 Certifying Physician: To the best of my knowledge, death ocolonly one) 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred at t leath occurred at the time, date and place	he time date and r	lace and due to the c	ausels) and manner stated
To veith		29b. Signature and title of cartifier Pledu > MD	29c. License number D46561	29d	. Date signed (Month	
TW-10		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince HT) WAS QUENTY (190 MI FERNA PEAD	nt)	11711-	, , , , , , ,	
State Registra	r	31. Date filed (Month Day Ya 2012 32 degistrar's Signature		N PEO		

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State of Maryland / Department of Health and Mental Hygiene

Physician Medical Centre				1 ■ For State		artment of Health a	nd Mental Hygi	iene	0 1015
Charles John BOOK A Posity have any fract custodors, pas with an analysis of the passes of the pass				Registrar	Cei	rtificate of Death			2 1345
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## Amsler MD D70027 4/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Amsler 11/6 Medical Campus drive Hagershown Maryl State 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	_	lospit 4 hour unera ely fille	dica	29a. Certifier 1 Certifying Physician: To the b	est of my knowledge, death or	ocurred at the time, date and pla	ace, and due to the cause	e(s) and manner as state	ed.
## Amsler MD D70027 4/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Amsler 11/6 Medical Campus drive Hagershown Maryl State 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature		the Pithin 2, the Fomplet		only one) 3 - Certifying Nurse Practitioner	To the best of my knowledge,	death occurred at the time, date a	and place, and due to the c	cause(s) and manner as s	tated.
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	,	0		Houzia Amsler	11116 Mea	tical Campu	s drive	Hagerston	un Marylank
			~	31. Date filed (Month, Day, Year) 8 2012 32. A	egistrar's Signature	and .		-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day PHILIP GLENN HAGUE MARCH 31 2012 8:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Min Hours Director 214-52-0326 **MICHIGAN** JULY 1964 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MARYLAND KENT ROCK HALL 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must ba any injuy or other traumatic event, the Medical Examiner must ba 5146 CROSBY ROAD 21661 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 OUTFITTER HUNTING HUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ PHILIP E. HAGUE FLORENCE PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5146 CROSBY ROAD ROCK HALL, MARYLAND 21661 TIFFANI G. HAGUE / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) STILL POND CEMETERY 04/04/2012 STILL POND, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. ich o ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complie ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or CAR DIAC ARREST Immediate Cause (Final Onset and Death Physician/ Myccardia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DERTENSION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day 1 Yes 2 g g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, yper lipidenua 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of TOBACCO 24a. Was an autopsy performed death? After this certificate 2 No 1 🗌 Yes 2 🖷 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ■ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 2

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

0.

29d. Date signed (Month. Day, Year

CHOSTES Faun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4R Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 10129 Century Drive Ellicott City Howard **Funeral** . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 215 16 1026 **Director** 1**X** M 2 □ F Yrs 86 May 11, 1925 Maryland Usual Residence of Deced 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 ☐ Yes 2 🔀 No MD Howard Ellicott City ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 10129 Century Drive 21042 United States · death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 L≝₹es . If Yes, Give 1 Yes 2 No Specify. "natural" 3 Divorced 4 Divorced Completed Specify: White Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry 721 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Sheet Metal Draftsman Ellicott Machine Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George W. Hansen Louise Hartten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health as Important: If item 27 is any injury or other trat Margaret Hansen/Wife 10129 Century Drive Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 4-16-2012 Hanover, MD eture of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 40 disease or condition resulting in death) ine Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform I ☐ Yes 2 ► No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 20No 1 Yes Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No ė 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) **₩**Natural 5 Pending Certifical Accident Investigation

the Hospital or Attending Physician: The law requires that the death certificate be executed ieral Director: A 24 hours Within 2

4 Homicide	determined	28e. Place of Injury - building, etc. (S	At home, farm, street, fapecify)	actory, office	28f. Location City or To	(Street and Number or Rural Route Number, own, State)	
Check 2°L	J Medicai Examine	er: On the basis of exam	ination and/or investigatio	on, in my opinion, death occurred.	at the time date	cause(s) and manner as stated. and place, and due to the cause(s) and manner so the cause(s) and manner as stated.	statec
29b. Signature and titl		28/1	no	29c. License number	7	29d. Date signed (Month, Day, Year)	,

bX

State Registrar

Medical

6 Could not be

Suicide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office

ted cause of death (Item 23a) (Type

APRIL 11,2012 0545 HEINE, URSULA

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed

			For	State of Marylan				Mental Hy	giene)		
		_	State Registrar	- 1	Cer	tificate of L	Death		Reg. No	2017	2, 13	3456
ı	Physicia Medic		Decedent's Name (First, Middle, Last Ursula	St)	Heir	ie		2. Date of De Month April	11, Da	2012 Year	3. Time 5:45	
74-	Examir	ner	4a. Facility Name (if not institution, give Shady Grove Adve		L	4b. City, Town, o		th		. County of Deat ontgomer		
	Funeral Director		5. Social Security Number 6. S 0 5 1 - 1 8 - 3 1 0 8 1 1 Usual Residence of Decedent	ex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 3 Year)	9. Birt 921 Ge 1	hplace (State Intry) Many	or Foreign
	Maryland 28a-f show stified at	Director	10a. State Montgo		y, Town or Lo	kville					10d. Inside (City Limits
	is 23a or 2 ust be no	Funeral Di	10e. Street and Number 9701 - Veirs	Drive		10f. Zip Code 20	850		10g. Cit	tizen of What Co USA	untry?	
9003	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.3 Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🛣No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Ame Black, White Specify: Wh	e, etc.	
1215-	e filed within 72 houn ital Hygiene. ed other than "natul event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Secretary			orking	16b. K	Steel Co.		
laryla	should be filed w and Mental Hygi is marked other raumatic event, f	To Be	17. Father's Name (First, Middle, Last) Henry Lunte	2 110	, 500	rocary		ame <i>(First, Middl</i> e, Marta		Surname)		
	4 5 E 12	190000	19a. Informant's Name/Relationship (1 Robert Heine-		19b. Mailing Address (Street and Number or Rural Route Number, City or Town 1718 P Street, NW, Washington,						Code)	
imore	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other ince.		20a. Method of Disposition 1 Burial 2 N Cremation 3 4 Donation 5 Other (Speci	Removal from State	cemetery, crem	metery, crematory or other place) opolitan Crematory 4/13						
Balt	permit. Pag Department Important; any injury o		21. Signature of Funeral Service Licen	Mar CCo36	$7 \mid \Pi$	Name and Addre	· Wast	nington	- DC	n Ave.N	1M	
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	Nigations that caused the deat one cause or each line. a. Due to (or as a consequence)	h. Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory ar	rest,		Approxima Interval Be Onset and	etween
	Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consequence of the consequence of t		, 1						
	suted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	c							***	
09.	cate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a consequent of the dot)	uence of):							
Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pi completed filled in by the funeral director, page 2 should be detached for use as the second state of the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fet: 4 Pregnant at time of 0 9 Unknown	resulting in the underlying cause given in Part I. 23e. Did to result in the underlying cause given in Part I.					23d. Date of delivery Month Day Year		
ds, P.O.	requires that the been signed by should be deta		Part II. Other significant conditions of	contributing to death but not res						i tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown		
Division of Vital Records,	The law requi ate has been page 2 shoul	Completed by						24a. Was auto perfe 1 🗆 Yes	psy ormed?	death?	topsy findings completion of 2 No	
ital	ysician; The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth	lace of Death (Ch					
n of V	iding Phys th. After this funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	1 🔀 Inpatient 2 🗆 28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	28c, Injur	4 □ Nursing y at	Home 5 Resi			ify)	
Divisio	al or Attending Phy s after death. Il Director; After this ed in by the funeral c	Certificate:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		ome, farm, str	eet, factory, office	n (Street and Number or Rural Route Number, Town, State)					
_	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check 2 Medical Exam	iner: On the basis of examinatio	owledge, death occured at the time, date and place, and due to the ation and/or investigation, in my opinion, death occurred at the time, of the firm who when the courred at the time, date and place, and due				date and place, and due to the cause(s) and manner stated			
	To the I within 2 To the I complex		29b. Signature and title of certifier	- m.D.		700 D	e number 6 5505	-	29d, Da	ite signed (Month	O Year)	
			29b. Signature and title of certifier 30. Name and address of person who Quiffeng Unng 1 31. Date filed (Month, Day, Year)	completed cause of death (Item MD 940/ Mca	n 23a) (Type, F	Center D	rive, R	e diville,	Mo	nnl/ Ion c	208	.50
	Sta Registr	re-	31. Date filed (Month, Day, Year) APR 1 7 2012	32. Registrar's Signa	park							
DH	MH 17 Rev 7/2	009	• .									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Prisicilla Abrtl 1 B. Harvison 13^{ay} 20 TZ 10:40 M Medical 4a. Facility Name (if not institution, give street and number, 9307 Glenville Road Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)19 Sept 25, 47 1 M 2 XF Days Hours 64 226-62-2736 Virginia Director Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Silver Spring 1 🖁 Yes 2 🗆 No ō 10e. Street and Number 10f. Zip Code 20901 ms 23a or must be n 10g. Citizen of What Country? 9307 Glenville Road Funeral U.S.A. items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, et 10 þ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Board (Specify only highest grade completed) Il Hygiene. life DO NOT use retired) Research Assistant Elementary/Seconday (0-12) College (1-4 or 5+) Federal Reserve permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othel any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Baker Loyce Johnson 19a. Informant's Name/Relationship (Type, Print)
Samuel Harvison-Husband 19b. Mailing Address/Street and Number or Bural Royle Number, City or Town, State, Zip Co 9307 Glenville Road Silver Spring Samuel 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Garctey, correction Heaven April21 SilverSpring, 4 Donation 5 Other (Specify) Robinson Funeral Home13136th St NWWash. DC 20001 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock heart failure. List only one cause on Interval Between Immediate Cause (Final disease or condition resulting in death) Hypoglycemic Coma Onset and Death Physician/ Medical Due to (or as a consequence of):
Diabetes Mellitus Type I Examiner Sequentially list conditions if any, each of the redict cause. Enter Underlying Cause (Disease or linjury Examine Date to (or as a consequence of, signed by the attending physician and defached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🕇 No | [0 Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Tes 2 No filled in by the Accident Investigation 3 Suicide
4 Homicide 6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi-29d, Date signed (Month, Day, Year) DO61891 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) Drive Silver Spring, Md. 20964

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM WASHINGTON HOCKER APR PM Medical 2012 4:40 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WRNMMC BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) ebruary 4 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Director 521-38-9279 79 Yrs. 1983 California Usual Residence of Decedent show 10a. State 10b. County Ħ 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Charles White Plains 1 Tes 2 No 10e. Street and Number ò 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 23a 4703 Diamond Ridge Lane 20695 USA 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2 Married If Yes, Give Year or Dates 1952-1975 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 □ Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th. Air Force Retired marked other Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Cleo Hocker Evelyn Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) uepartment of Health a Important: If item 27 is any injury or any William A. Hocker/ Son 12394 Charles Street, LaPlata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets' Cem. April 16, 2012 Cheltenham, MD 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee M@1[9⊘8035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition RESPIRATORY DISTRESS Medical resulting in death) Due to (or as a consequence of): Examiner AORTIC STENOSIS Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Due to (or as a consequence certificate be executed Cause (Disease or iinjury that initiated events and-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Day Pregnant at time of death Month Year Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗆 No Yes 2 X No 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tyes Other: ျှ 2 🗓 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the Hospital or Authority within 24 hours after death.

To the Funeral Director, After X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: Te the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Ba-15

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

DHMH 17 Rev 7/2009

sark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

DOUGLAS F. POWELL,

APR 1 6 2012

NE 24489

WRNMMC, BETHESDA, MD 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Linda Hendrix Η. 1:30 P M Apri] Medical 06. 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 216 McKinsey Road Severna Park Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 215-40-0974 **Director** 1 🗆 M 2 🕱 F 68 June 15,1943 Maryland 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel MD Severna Park 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 216 McKinsey Road 21146 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ò ð 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 'natural", Completed 3 Widowed 4 Divorced Specify 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Trust Officer Real Estate Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ Randolph Horine Inez Cullison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Hendrix / Husband 216 McKinsey Road Severna Park, MD 21146 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or oth once, 20c. Location - City or Town, State April 09 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC: 2012 Signature of Funeral Service Live s of Facility Sons , P.A. Severna Park Funeral H Severna Park, MD 21146 495 Ritchie Hwy 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition year. Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical ul or Attending Physicians. The law requires that the death certificate be earlier death.

Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant 3 Ctopic pregnancy
5 Other (specify) ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day signed by the at I be detached fo Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes plnous Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State within 24 hours a

To the Funeral D Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Typerint)

Most

Poornima Sharma, M.D.

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only one 29b. Signarur

203 Hospital Drive Suite 312 Glen Burnie,

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Menth, Day, Year)

MD

9

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 🔏 Physician/ Medical Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 101 Hilltop Drive Severna Park Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 548-30-3079 Days Director 1 M 2 A 87 Apr. 07,1925 Oklahoma Usual Residence of Deceder 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director items 23a or 28a-f s ier must be notified MD Anne Arundel Severna Park 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 101 Hilltop Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc 9 þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify "natural" Completed 3 X Widowed 4 Divorced Specify: Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Mer Elementary/Secondary (0-12) College (1-4 or 5+) 9 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve ည unk Ruth Holland Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12031 Twin Cedar Lane Bowie, MD 20715 Judy Kline / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State April 12, Crownsville, MD MD Veterans Cemetery Donation 5 D Other (Specify) 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part . Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the hurial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day 4 Pregnant : 9 Unknown Pregnant at time of death 9 Unknown Division of Vital Records, P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director. After this certificate has autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical within 24 hound to the second 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier ise of death (Item 23a) (Type, Print) 30:Wame and address of person

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

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Amend #1 per 1 AACO Health De	PH:	7 1 13 13 13 17		Type or							•		_	ble.		
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Examine	er	4a. Facility Name (if ANNE ARUN					4b. City, To			of Death			c. County) FT	
Funeral		5. Social Security No		Sex Sex	7. Age (In yrs. la	ast birthday)	If Under		If Under Hours	24 Hrs. 8	3. Date of Bir (Month, Da	th			lace (State	e or Foreign
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21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	þ	1 ☐ Never Marri 3 🛣 Widowed	ied 2 Married	If Vas Giv	2 🔲 No		1 Yes 2				can, etc.)		Black Specify:	k, White, פ אורד דון		
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land be file fental rrked o	2	WILLIAM									HEIBE		r Surriame,			
Maryland 21215-0036 12 should be filed within 72 hours after aith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam.		19a. Informant's Na	ame/Relationship (Type, Print)		19b. Maili	ng Address (Street a	nd Numbe	er or Rural F	Route Numbe	er, City c	or Town, St	ate, Zip C	Gode)	
e, N and 2: Health em 27 ther tr		MICHAEL 20a. Method of Disc		/SON	OOL D	30 B			<u>AVEŅU</u>		SADENA					
imor Page 1 nent of I ant: If it		1 🗆 Burial 2	Cremation 3 5		State CHE	APEAK ER	natory or oth E CREM	iATI	ÖN ,	Da			Location -	-		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fair			CEN.	22	2. Name and	Addres	s of Facili	1/10/2 LASTI	NG TR	IBUT	VENS ES B	Y FEI	LLOWS	
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		23a. Part 1. Enter t shock, or hear Immediate Cause (rt failure List only	nplications that one cause on ea	caused the deatl	n. Do not ent	er the mode	of dying	g, such as	cardiac or r	respiratory ar	rest,			Approxin	
Physician Medical		disease or condition resulting in death)	on .	a. Due to	(or as a consequ	1+P	ron	24 7	fau	em				- 1	VIY	5
Examiner	<u>-</u>	Sequentially list co	nditions,	b. —			Hy fe	w	ens	ion					4.0	0-
ted Insit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	injury	Doeto	(ui as a cunsequ	ience uij.	/								/	
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ox 68760 eath certificate be attending physicial I for use as the bu	by Physician/Medical			d												
687 certific nding use as	Ž Ž	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out	come of pregna Birth 2 Feta	ncy	75						23d. Date	e of delive	ery	
Box death he atte	sicia	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No		nant at time of c		Other (spe		у				Mor	ith	Day	Year
ords, P.O. Be requires that the debeen signed by the should be detached	, Ph	Part II. Other signif		contributing to d	eath but not res	ulting in the u	ınderlying ca	ause giv	en in Part	l.	23e. Did t	obacco	use contri	bute to th	e cause o	f death?
IS, Fuires the night be	od be		11	chex	er						1 🗆	Yes 2	2 🗆 No	3 🗌 Prob	ably 4	Unknown
Sorc w requas been 2 shou	Completed										24a. Was		24b. W	ere autor	osy finding	s available f cause of
/ital Reco sician: The law i certificate has b director, page 2 s											perfe 1 \square Yes	ormed?	d	eath?		
/ital	To Be	25. Was case referre examiner?		Hospital:	Inpatient 2 🗆	EB/Outratia	- 2 T DO	Othe	r'	th (Check o			a 🗆 au	10 11		
of \rangle		27. Manner of Death	h	28a. Date		28b. Time of injury		c. Injury work	at		e 5 🗆 Resi d. Describe					
ion tendin death. tor: Aff	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not	on be			М	1 🗆 `	Yes 2							
Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate brs after death. In Director. After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the tention by the funeral director, page 2 should be detached for use as the tention.		4 🗌 Homicide	determine	d 28e. Place buildi	of Injury - At ho ng, etc. (Specify	me, tarm, str	eet, factory,	office		28	3f. Location (City or Tox			r or Rural	Route Nu	nber,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2		niner: On the bas	sis of examination	and/or inves	tigation, in m	y opinio	n, death o	courred at th	e time, date	and plac	e, and due	to the cau	ise(s) and i	manner stated.
ro the within 2 ro the comple	ž	only one) 3 29b. Signature and	title of certifier	rse Practitioner	: To the best of n	ny knowledge			ne time, da number	te and place	e, and due to		e(s) and m		tated. Day, Year)	
		mm.	11	Nei	An m			0	ント	f38		X	Ju	N	02	0/2
(141)		30. Name and addre	ess of person who	completed calls	se of death (Item	23a) (Type, F	Print) D	EFÉ	WE	Hav	y A	Nal.	APOL	ON	102	1401
State Registra		31. Date filed (Mont	h, Day, Year) APR 122	012 32. 8	gistrar's Signat	ure	have				1					
-10910414					-	1. 1.	4									

State Registrar

within 2

(Check only

29b. Signature and title of certifier

Chandra Korapati, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney stated.

29c. License number

MD52855

29d. Date signed (Month. Dav. Year)

10, 2012

April

7207 Hanover Parkway; Suite B

Greenbelt, Maryland 20770

			For	State of Mar	ryland / Dep	artment of I	Health a	nd Mental Hy	giene 20	12 1346				
_			State Registrar		Cei	rtificate of L	Death		Reg. No.	12 1040				
	Physicia	in/	1. Decedent's Name (First, Middle, Las	,	: 			2. Date of De April 9		3. Time of Death 8:27 PM				
, gud	Medic Examir		4a. Facility Name (if not institution, give	Chester H:	rggrubotna	4b. City, Town, o	r Location of		4c. County of					
-	A		18200 Bivens P1	ace			Accoke			e George's				
	Funeral	Г	5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th 9	Birthplace (State or Foreign Country)				
	Director		226-32-6709 Usual Residence of Decedent	M 2□F	81 Yrs.			Sept. 4		Virginia				
	and show	5	10a. State 10b. County	1	Oc. City, Town or Lo	cation	1	Ворол	,	10d. Inside City Limits				
920	Maryl 28a-f otifie	irec	DC				Washi	ngton		1 🔀 Yes 2 🗌 No				
	h the	a D	10e. Street and Number	240		10f. Zip Code			10g. Citizen of Wha	at Country?				
	ath wifi ms 2: must	Funeral Director	214 V Street NI	12. Was Decedent Eve	- i- 11 C 40 1	No December 111	2000			ted States				
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.		was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, White, etc. Black				
15-(72 hou n "nat ledica	Completed	15. Decedent's Ed (Specify only highest gra	16b. Kind of Busin	ness/Industry									
712	vithin jene.	Con	Elementary/Secondary (0-12) 9th	College (1-4 or 5+)	life. D	O NOT use retired) Chef			Gove	ernment				
þ	illed wall Hyg	Be	17. Father's Name (First, Middle, Last)			Onci	18. Mother's	s Name (First, Middle,		21 mmcire				
ylar	Ild be f Menta narked atic ev	욘	Thoma	s Higginbot	tham			Alberta	me (First, Middle, Maiden Surname) Alberta Williams					
, Maryland 21215-0036	nd 2 shou ealth and m 27 is n		19a. Informant's Name/Relationship (Ty Caroline Higginbot					Accokee,		e, Zip Code) 20607				
Baltimore,	Page 1 ar nent of H int: If iter iny or oth		20a. Method of Disposition 1		20b. Place of Dispo cometery, crer Chestn Bapt Chu	natory or other place ut Grove	April 15, 20c. Location - City or Town, State Nonroe, Virginia							
Salti	epartn epartn nports ny inju		21. Signature of Funeral Service Licens	ee f		2. Name and Addre		Stewart F						
ш	20589							ad NE Was		DC 20019				
احر	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.		er the mode of dyin	g, such as ca	rdiac or respiratory an	est,	Approximate Interval Between Onset and Death				
3300	Medical Examiner		resulting in death)	Due to (or as a c	STERVINE TO STERVI					years				
	ed sit	Examiner	Sequentially list conditions, if any leading to humodiate cause. Enter Underlying Cause (Disease or injury	years										
	icate be executed physician and is the burial-transit	Exal	Cause (Disease or Injury that initiated events resulting in death) Last C. High Blood Pressure Due to (or as a consequence of):											
09	hysicia the bu	dical		d				<u>,</u>						
687	ertifica ding p		IF FEMALE:	23c. If yes, outcome of	pregnancy									
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Fetal death 3	Ectopic pregnand Other (specify)	Ey		23d. Date of delivery Month Day Year					
	s that gned b	by F	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribu	se contribute to the cause of death?				
rds	een si een si	eted	7	/es 2 ☐ No 3 [☐ Probably 4 🔀 Unknown									
Division of Vital Records,	Physician: The law r r this certificate has b aral director, page 2 si	Completed												
ital	sician certifi irector	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	or.	(Check only one)	Daugh	ther's.				
<u>}</u>	y Physer this eral d	e: To	27. Manner of Death	28a. Date of injury	2 ER/Outpatier 28b. Time of	at 3 DOA 28c. Injury	4 L Nursi		ence 6 Other (Sourced	Specify)Residence				
ono	ending eath. or: Afte he fun	ficat	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Y	<i>(ear)</i> injury	work	? Yes 2□No	ı	ow injury occurred					
Divisi	pital or Attending Phours after death. eral Director. After thi	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (5				r Rural Route Number,						
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check 2 L Medical Examin	ician: To the best of my ner: On the basis of exan e Practitioner: To the b	nination and/or invest	igation, in my opinic	n, death occu	rred at the time, date a	nd place, and due to	the cause(s) and manner stated.				
	To the within 2 To the comple	2	29b. Signature and title of certifier			29c. License			29d. Date signed (M					
	6		That	DO			34313		April 12,	2012				
	2	2	30. Name and address of person who co	· ·	h (Item 23a) (Type, P Washingt (,	0001 .	Tara East	in MD					
F	Stat	e	31. Date filed (Month, Day, Year)	32 Begietrar's	Signature									
	Registra		APR 1 3 2012 /	eneral D.	parke									

Please Type or Print in Black Indelials Ink, Fraure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year Mary Lucille Herbert April 9:15 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 39577 Golden Beach Road Mechanicsville St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) **Director** 1 □ M 2 🛣 F 214-34-6562 83 02/23/1929 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland St. Mary's Mechanicsville 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 28275 Thompson Corner Road 20659 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 X Married nours after 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White 'natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) Il Hygiene. College (1-4 or 5+) Board of Education School Teacher Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Dotson Ernest Montgomery Josephine Knight Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Black / Daughter Department of Health mportant; If item 27 39577 Golden Beach Road Mechanicsville, MD 20659 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/10/2012 Queen of Peace Cem. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, PA M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ brea. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying that the death certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed? Yes 2 2K No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital daughter's 2 **2**No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spe nours after death.

neral Director: After this y filled in by the funeral di After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1, Letrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

DHMH 17 Rev 06-2011

State Registrar Motch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28103

Three

Bauer

Dr. Karen

162042

Ste 101, Mechanicsville, Md. 20659

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic		Registrar	ificate of Death	Reg. No.					
al Exam		Decedent's Name (First, Middle,Last) Translation T		Date of Death Month Day Year					
ai Laaiii	11161	Kristy Dawn Jenkins 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	7,011 10, 2012					
		Meritus Medical Center	Hagerstown	Washington					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 214-27-1160 1_M 2XF 25	Martha Dava Harris IN	The state of					
ROY		Usual Residence of Decedent 10a, State 10b, County 10c, City, To	own or Location	10d. Inside City L					
E	_	Maryland Washington	Hancock	1 Yes 2X					
Maryland 28a-f show d at oocc.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
th the 1 23a or potifie		14709 Indian Springs Rd.	21750	USA					
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of fleath and Mental Hygiene. Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be softlied at ooce.	Funerai	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 						
lr, or		3 Widowed 4 Divorced If Yes, Give Yeer	1 Yes 2 No specify:	Specify: White					
nours a natura Exami	leted by		6a. Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use re						
in /2.	plet	Elementary/Secondary (0-12)	Student	Education					
lygienc other he Me	Compl	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)					
ental F arked vent, t	Be	Michael Dale Jenkins		Annette Palmer					
and M	₽	19a. Informant's Name/Relationship (Type, Print) Donna A. Rankin - Mother		Rural Route Number, City or Town, State, Zip Code) Rd. Hancock, Maryland 2175					
Health item 2		20a, Method of Disposition 20b, Pla	ace of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State					
rages ent of nt: If		Total 2 Goldano Carlova non State	e Hill Cemetery Apri	1 20,2012 Clear Spring, Marylo					
spartm nporta jury o		21. Signature of Funeral	A HRATE HERE THE COMPANY H						
		23a. Part I. Enter the disease, or complications that caused the death. D		St. Williamsport, Maryland 21795					
ysician ledical		failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Into Between Onset Death					
Immediate Cause (Final disease or condition resulting in death) Let under the condition resulting in death or condition resul									
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nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):							
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DHMH 17 Rev 06-2011

State Registrar

JORDAN

DERRICK

12-02716 Robert Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Johnson		- For State tegistrar	State	of Maryland		rtment of tificate of			Menta		Re	g. No.	201	2 1346
Physicia	n/	Decedent's Name	(First, Middle,Last)			-	-			l M	ate of Death	Day	Үеаг	3. Time of Death 2204 hrs
Medical Examin		Robert	Lee J	ohnson			4b. City, To	own, or Lo	cation of		oril 5, 20		unty of Death	22011110
		•	ges Hospital C				Cheve	rly				Princ	ce George	's
Funeral Director	- 1	5. Social Security N $240-40-3$			e (In yrs. la:	st birthday) B1 Yrs	Months	1 Year Days	If Under: Hours		eb.1	•	Foreig	hplace (State or n uotox)
h		Usual Residence of 10a. State	Decedent 10b. County		Inc. City	Town or Locati	ion							10d. Inside City Limits
1 100 M 209	_	MD	PG			tchell		.e						1 X Yes 2 No
Maryland 28a-f show d at oocc.	Director	10e. Street and Nun					10f. Zip	Code					of What Cour	
ith the Maryland 23a or 28a-f sho cotified at ooce		3800 L	ottsford	l Vista_	Road		l	2072					ed St	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. A other than "natural", or items 23a or 28a-fake i, the Medical Examiner must be socified at ooce	Funeral	11. Marital Status 1 Never Marrie	_	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Yeer		If Y		Cuban, M	1exican, F	n? (Specify Puerto Rica	Yes or No- in, etc.)	'	Race - Ameri White, etc. ^{cify:} Bla	can Indian, Black,
irs afte	<u>a</u>	3 X Widowed 15. Decedent's Ed	4 Divorced	or Dates:		16a. Deceder	t's Usual (ccupation	(Give kir		done		of Business/I	
72 hou n "nat	Completed	Elementary/Seco		College (1-4 or		during m	ost of worl	ing life. D	O NOT u	se retired)				
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21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "nature e event, the Medical Exam	B B	17. Father's Name (Haywood		on.						nces		zier		
Me Me	의	19a. Informant's Na	me/Relationship (T	rpe, Print)		19b. Mailing	Address 3rd	(Street a	nd Numb	er or Rucal E #20	Route Num	ber, City or	Town, State	, Zip Code)
MD and 2 sho alth and 2 in 27 is	-	Michael 20a, Method of Disp	Johnson	n/son	20b P	Wash lace of Dispos	inat	on.	DC_{-}	2000 Da	32		ition - City or	
Baltimore, MI permit. Pages I and 2.8 Department of Health a Importact: Witem 27 injury or other traum.		1 X Burial 2	Cremation 3	Removal from St	ate c	rematory or ot Vete	her place)		- 14	4/18,	/12	Chel	tenha	m,MD
it. Partiment ortaot	+	4 Donation 5 21c Signature of Fu	Other Specify: neral Service Licens	see A	Ma.	22. N	lame and	Address of	Facility	Hode	ges &	Edw	ards	F.H.
Department of the partment of	- 1	(XDOM)	na H	odace	_	39	10 S	ilve	er H	ill 1	Rd.,	Suit	land,	MD.20746
Physician Medical		23a. Fart I. Enter th ailure. List on	e disease, or comp ly one cause on ea	ch line.			he mode o	f dying, su	ich as car	rdiac or res	piratory arre	est, shock, o	or heart	Approximate Interval Between Onset and Death
Examiner	- [Immediate Cause (or condition resulting		Congestive Headure to (or as a cons										5000
		Sequentially list co	nditions.	Hypertensive A	theroscle	erotic Card	iovascu	ar Dise	ase					
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ficate be g physicist the buri	8	IF FEMALE: 23b. Was decedent		23c. If yes, outco	me of pregr		etal death	3	Ectopic i	pregnancy		23d. Da Mor	ate of delivery	v Day Year
Box 6876 e death certificate the attending phy led for use as the b	Physician/M	past 12 months		4 Pregnant a	t time of dea	=	ther (Spec	ify)						
Bo he deal he deal y the at hed for	hys	1 Yes 2 1		9 Unknown contributing to dea	th but not re	esulting in the	underlying	cause giv	en in Parl	t I.	23e. Did to	bacco use	contribute to	the cause of death?
Division of Vital Records, P.O. Box 6876 pital or Attending Physician: The law requires that the death certificate ours after death. seral Director: After this certificate has been signed by the attending phy filled in by the funeral director, page 2 should be deached for use as the	ā		structive pulmo								1 Yes	2 No	3 Prot	oably 4 🗹 Unknown
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Div	Certification:	4 Homicide	determine	10/1000										
Division of Vital Records, P.O. Box 6876i To the Hospital or Atteoding Physician: The law requires that the death certificate within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l	Medical	29a. Certifier (Check only one) 2	Medical Examine	an: To the best of r On the basis of exand manner stated	amination a	ge, death occu nd/or investiga	ation, in my	opinion, o	death occ	ce, and due	to the caus time, date	and place,	and due to th	e cause(s)
F \$ F 5	ž	29b. Signature and	title of certifier	11	T		290	O.C.M				29d. Date April 6,		nth, Day, Year)
(1)		/4/	ress of person who	completed course of	death (Item	23a)		J.O.IVI						
MAGA		30. Name and add		completed cause of ssistant Medica			V. Baltin	nore Str	eet, Ba	altimore,	MD 2122	23		
	ate	31. Date filed (Mor		32. Regis	ar's Signati									
Regist			variation (Car											

DHMH 17 Rev 1/2001 OCME 2006

COME ...

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day 2012 Year Physician/ 5, 0500 Dorma Joyner-Lippincott Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) Jan. 11, 1924 Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Country) Virginia 1 □ M 2 🖾 F Hours **Director** 577-34-8736 88 Usual Residence of Decedent 28a-f show 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 635 Edgewood Street NE # 505 20017 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 🖾 No Specify: Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bertha Lee Otis Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 the Health. 239 Georgetown Court Royersford, PA Keith W. Joyner - Son Important: If item 2, any injury 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 19, ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 4 Donation 5 Other (Specify) Arlington, Virginia 2012 emetery 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service Licensee Inc. M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of for use as the burial-transit Morolasi that initiated events resulting in death) Last the attending physician covascular Dosceaso Physician/Medical Box 68760 IF FEMALE: ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Garage 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown director, page 2 should be detached P.O. à Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate noma 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injury 1 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State

Registrar

Rd # 216

ROCKVILLE MAS 20852

of person who completed cause of death (Item 23a) (Type, Print)

Illed (Month, Day Year)

2012

31. Date

Randolph

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death A PR Year Physician/ 11.25AM FFERSON UANITA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Burtonsville Sanctuary At Holy Cross If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months 10-6-1930 Buckhannon, WV 81 Director 269-36-3720 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland **Funeral Director** 1 X Yes 2 No Hyattsville MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20782 2311 Woodberry Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: If Yes, Give "natural", 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Domestic <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Valeria Powell Warren Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hyattsville, MD 20782 Linda Arnett (Daughter) 2311 Woodberry st 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Fort Lincoln Crematory 4/12/2012 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Se dicenses Brentwood, MD 20722 3401 Rd. Bladensburg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Divi to for as a nonsequence of: If any, leading to immedicause. Enter Underlying transit-Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No page 2 should be detached for Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Natural 5 \square Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 285

Registrar
DHMH 17 Rev 7/2009

State

1ASNECM
31. Date filed (Month, Day, Year)

Box

1525

WINGS

MILL MA 21117

30 Name and address of person who completed cause of death (Item 23a) (Type, Finit)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4 20°12 9:28 РМ Morton Koff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 15115 Interlachen Drive #801 If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) Director 165-12-9981 1 🛛 M 2 🗆 F 91 3-14-1921 PA 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 □ No MD Silver Spring Montgomery 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral death with 20906 United States 15115 Interlachen Drive #801 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 0.5.

Armed Forces?

1 X Yes 2 No WWII

f Yes, Give Black, White, etc and 2 should be filed within 72 hours after of Health and Mental Hygiene. tem 27 is marked other than "natural", or 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+Medical Podiatrist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Koff Molie Mirkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15115 Interlachen Dr., #801, Silver Spring MD, 20906 Jennie Koff - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I Important: If ite any injury or ot once. Page 1 1 🔀 Burial 2 □ Cremation 3 □ XRemoval from State King David Mem. Gadns. 4-10-2012 4 Donation 5 Other (Specify) Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel M00910 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Lymphoid Leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last as the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? Month Dav Pregnant at time of death signed by the a lid be detached f 2 🗌 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown this certificate has been sirral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director. After this certificate h completely filled in by the funeral director, page 2 No 1 Yes Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

17

Debrah Miller, CRNP -

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R143201

1355 Piccard Drive, Ste. 100, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 April Physician/ Theodore Klein 11, 7:29 AMMedical 4b. City, Town, or Location of Death Rockville 4a. Facility Name (if not institution, give street and number) Examiner Ac. County of Death Montgomery Rockville Nursing Home 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthday, **Funeral** (Month, Day, Year, Days Hours 128-22-8647 Director 1 🕅 M 2 🗆 F 89 09/18/1922 Czechoslovakia 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shorexaminer must be notified at 10b. Count 10a. State with the Maryland Director 1 Yes 2 □ No Rockville MD Montgomery 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20850 303 Adclare Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1940—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 _{Specify:}White 1 Yes 2 X No Specify: "natural", Completed 3 Midowed 4 ☐ Divorced Year or Dates 1945 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Government Officer Intelligence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eugene Klein Blanche Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth McKenna / Daughter 660 Hillcrest Way Emerald Hills, CA 94062 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 X Cremation 3 Removal from State 4-13-2012 Falls Church, VA National Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. uneral Service ucensee Signature/bi 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Dementia Exami and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Coronary Artery Disease nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death been signed by the s should be detached g Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? death? Yes 2 No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 5 Pending injury 124 hours after death.
Funeral Director: Aft letely filled in by the fur Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Promision 2

State Registrar only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Thomas Joseph 50W Edmonston Dr. Suite 207, Rockville, MD 20852

DIMIN

D0047330

4-12-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 4 State of Maryland / Department of Health and Mental Hygiene WCHD/TF 4/20/20=b2 PER FH
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kelly Eva Dolores 2012 9:10 p Apri] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Williamport Nursing Home Williamport Washington 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 219-14-8691 1 M 2 F Davs Yrs **Director** 1925 Maryland 214-19-8691 Usual Residence of Decedent 86 <u>May 1</u> 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f 1 Yes 2 No Washington Hagerstown MD 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ö must be 23a by Funeral U.S.A. 21742 1425 Glenwood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Force Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural" 3 Widowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the and Mental Hygien 7 is marked other t Domestic 11 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mamie Bitner Nevin Barr traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Kelly / Son 16960 Edward Doub Road, Williamport, MD 21795 or other tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/19/2012 Rest Haven Cemetery Hagerstown, Maryland e Licensee of Funeral Servi 21. Signatur 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition UROSEPSIS Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjurathat initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physiciar certificate be 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day ed by the a detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ADVANCED SENTLE DEMENTIA 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MELLITUS HABETES has performe 2 🗌 No Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending ter death. М 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours after a Funeral Direc determined Medical 29a, Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. peted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2
To the I comple Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 33700 *K 7012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMSFORT HOWE 15 ACTIZAN ST State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 8 Physician/ ^{Day} 2012 David Preston Koontz 7:30 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1300 Pinewood Drive Frederick Frederick Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 215-82-6568 48 Director 1 X M 2 □ F 06/11/1963 Maryland Usual Residence of Deced 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Frederick Frederick MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 1300 Pinewood Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black. White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Sales Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry E. Koontz Karen Ann Stouffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Pinewood Dr., Frederick, MD 21701 James Hulse/domestic partner 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 4/11/2012 Smithsburg, MD 22. Name and Address of Facility Reeney & Pastord Funeral Home 21. Signature of Funeral Service Licenses Dhe lere MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ proiovascular disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine any, reading to mined ate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, for use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 es, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant : Pregnant at time of death been signed by the s To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier of gerson who completed cause of death (Item 23a) (Type, Print)

State Registrar . Date filed (Month, Day, Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Day Lottie R. Klimchak q 2012 Medical 5:30a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Citizens Care and Rehab. Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 209-16-7411 91 1 □ M 2 🗶 F OCT.2,1920 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Howard Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17536 Frederick Rd. 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 11 Machine Sewing operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Casper Klimchak Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Balbina Hudyka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Reese / daughter 17536 Frederick Rd./ Mount Airy, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place 4 Donation, 5 Other (Specify) Pine Grove Cemetery 04/11/2012 Mount Airy, Maryland . Signature of uneral Servi 22. Name and Address of Facility e and Address of Facility Stauffer Funeral Home Ridgeville Blvd./Mount Airy, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ ent Bru ASCULAR. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): nding physician use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy 5 Other (specify) in the past 12 Month Pregnant at time of death Day Year 1 Yes 2 No g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Hospital: Other: 1 Tes ြို 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' M 1 🗌 Yeş 2 No Accident Investigation within 24 hours after death

To the Funeral Director;

completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier IM 2

Registrar
DHMH 17 Rev 06-2011

State

11BTE

31. Date filed (Month, Day, Year)

814

Toll House AVE Frederick

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

MM

32. Registrar's Signature

KAZMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Bernadette Inez King 2012 5:20 Medical ам 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mt. Airy Shamrock Gardens Assisted Living Howard 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 215 18 3320 Hours Director 1 M 2 X F 02/10/1923 89 MD Usual Residence of Decedent be filed within tanks.

Sental Hygiene.

arked other than "natural", or items 23a or 28a-1 silvented other than "natural", or items 23a or 28a or 28a or 28a show 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No MD Howard Woodbine 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 16292 Carrs Mill Road 21797 United States Was Deceud.
Armed Forces?
Vas 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant 12 Federal Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o ပ traumatic Thomas Greenfield Maud Curry uepartment of Health an Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jane King - Daughter 16300 Carrs Mill Road Woodbine, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Crest Lawn Mem. 04/16/2012 Marriottsville, MD ^{22. Name and Address of Facility} Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licenses Them Colle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prosiciary Medical **Examiner** ipital Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a co requence of) involving belateral UDAR and -trar physician are the burial-1 Due to (or as a consequence of Physician/Medical that the death certificate be Box 68760 ass attending yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Successful at time of death 5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ vessel Records, ischemia Completed 1 Yes 2 No 3 Probably 4 Unknown hrombo cytopen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy features · Parkinsonia performed' Hospital or Attending Physician: The Yes 2X No 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one, Hospital: Other: 1 🗌 Yes 2 🔀 No ည this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify Asstd. Lvg s after death.

I Director: After this of in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours aft the Funeral Di mpletely filled ir Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29d, Date signed (Month, Day, Year) R050640 April 12, 2012 person who completed cause of death (Item 23a) (Type, Print) 4202 Green Valle, Rd. Monrovia Mi CRNPA 21701 Date filed (Month. 32. Registrar's Signature State Registrar

mended #	18	Fier State Registrar TCHD, 04/		arylan	d / Depa		Health a	and Mental Hy	giene	-egible. 2 N 1 2	131.76
Physicia Medic	n/ al	1. Decedent's Name (First, Middle, I Jean Rob	inson			her		2. Date of De Month	The grant of	Year / 2	3. Time of Death 3./2.AM
Examir		4a. Facility Name (if not institution, g 28544 CLUBHOUSE	DRIVE			4b. City, Town, o		of Death		ounty of Death	1
Funeral Director		140-20-2412	7. Ag 1 □ M 2 🏋 F	e (In yrs. Ia 84	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Bir Min. (Month, Da	y, Year)	Cou	hplace (State or Foreign intry) W JERSEY
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th the Ma 3a or 28a t be notif	Funeral Director	MD TALBO		EA	STON	10f. Zip Code			10g. Citize	en of What Cou	1 X Yes 2 □ No untry?
Ind 21215-0036 I filed within 72 hours after death with the Maryland tal Hygiene ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	28544 CLUBHOUSE 11. Marital Status 1 Never Married 2 X Marrie	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give		l II	Vas Decedent of Haras Specify Cuba	an, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	:	Race - Amer Black, White	, etc.
215-00 in 72 hours e. nan "natura Medical E	Completed	3 Widowed 4 Divorced 15. Decedent' (Specify only highest Elementary/Secondary (0-12)	Year or Dates. s Education grade completed) College (1-4 or 5	5+)	(Give F	ent's Usual Occup ind of work done O NOT use retired)	during most	t of working		of Business/l	
ind e filed tal Hy ed oth event	l as l	12 17. Father's Name (First, Middle, Las JAMES PATTERSOI	2 2 st)	<u> </u>	HOMEM	IAKER		er's Name (First, Middle,	Maiden Sur		
re, Maryla 1 and 2 should be f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship ROBERT KAERCHER			1	_	and Numbe	er or Rural Route Number	er, City or To	wn, State, Zip	Code) 30012
no age ant o		20a. Method of Disposition 1	ecify)	CE	imetery, crem LINGTO	sition (Name of natory or other place N CEMETE)	RY 2	Date 4/13/2012		tion - City or T	Town, State NEW JERSEY
		21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or conshock, or heart failure. List onl Immediate Cause (Final	omplications that caused y one cause on each line	the death e.	Do not ente	r the mode of dyin	HELFEN HARRI Ig, such as	NBEIN & NEW SON STREET cardiac or respiratory ar	EAST	FON, MT	Approximate Interval Between
Prysician Medical Examiner		disease or condition resulting in death) Sequentially list conditions,	Due to (or as a factor)	ONG a consequ		Anti	lat	ion	436		Gears Jeans Years
be executed ician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a Due to (or a) D	tic	: S	teno	Sis	Α.			years
	edical		L. Cond	Ruc	tion	7 545	tem	Diseas	se		months
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate Learner death. Funeral Director, After this certificate has been signed by the attending physistely filled in by the funeral director, page 2 should be detached for use as the I	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	СУ		230	d. Date of deli Month	very Day Year
ords, P.O requires that the bear signed by should be deta	d by Pł	Part II. Other significant conditions CLVL 615 V	s contributing to death b		Ulting in the u		ven in Part l				the cause of death?
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director, completely filled in by the	al Certificate:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of Inju	c. (Specify)				Gity or Tov	vn, State)		al Route Number,
the Hosp hin 24 hou the Funer mpletely fi	Medical	(Check 2 Medical Exaconly one) 3 Certifying N	hysician: To the best of aminer: On the basis of e lurse Practitioner: To th	xamination	and/or invest	gation, in my opinio death occurred at	on, death oc the time, dat	curred at the time, date a	and place, ar	nd due to the c	ause(s) and manner stated.
TLS		29b. Signature and title of certifier	don		m	29c. Licens	757	859	41	signed (Month)	, Day, Year)
10		Rabent	5 m ol			609	De	tchma.	12'5	Lar	e, Easta
Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 201	2 3. Registra	ar's Signatu	ure form	20					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kline, Sr. Terry 7:36 A M Lee April 18 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 400 South Main Street Woodsboro Frederick Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday, **Funeral** Country) Maryland Months Days Hours 212-50-8416 **Director** Dec. 19, 1947 1 X M 2 □ F 64 Yrs. Usual Residence of Deced ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21.798 400 South Main Street should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items raumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automotive .10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Catherine Kline Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 South Main Street, Woodsboro, Maryland 21798 Patsy Kline / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 20. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Lice Kency and Basiord PA Funeral Home, MO1473 106 Fast Church Street, Frederick, Maryland 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 4theroscleroti disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury -transit and that initiated events Due to (or as a consequence of): resulting in death) Last as the burialthe attending physician Physician/Medical P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached Unknown the Hospital or Attending Physician: The law requires that the signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 Yes 2 No **Division of Vital** filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Director: After (Month, Day, Year) 1 Natural 5 Pending М Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours Medical 1 📃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistratMFND#20a,b,c,perFH,4/16/12;BMV,MCCCCertificate of Death 2. Date of Death Physician/ April 12, Helen Day 2012^{eai} Frances Lun 4:40 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Renaissance Gardens at Riderwood Villag Silver Spring P.G. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days March 13, 1 M 2 X F 91 Yrs. 215-18-6544 **Director** MD Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No MT P.G. Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road, OG-3113 20904 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, e White Specify: White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates nit. Page 1 and 2 should be filed within 72 hour afterment of Health and Nental Hygelen. ortant; If item 27 is marked other than "natun injury or other traumatic event, the Medical injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick John Keesler Alice Hessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica M. Zeller/Personal Rep. 1323 Chapel Hill Drive, Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Alexandria, Virginia Department of I-Important; If ite any injury or oth April 20, Burial 2X Cremation 3 Removal from State Metropolitan chromator St. Magymot the Mills 4 Donation 5 Other (Specify) 2012 Laurel, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani Chronic Obstructive Pulmonary Disease disease or condition years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Year Day Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease Division of Vital Records, 1 \boxtimes Yes 2 \square No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b page 2 s performed 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔼 No Hospital Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA pempleted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending work М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D24035 April 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Eugenio Machado, MD 31. Date filed (Month, Day, Year) State

Registrar

		-	State of Marylan		artment of F			21	112	13	1,79
			Registrat/END#26perMD,4/25/12;BWi,McCo 1. Decedent's Name (First, Middle, Last)		incate of L	Jean	2. Date of De		J 1 C	3. Time of	Death
	Physicia Medic	al	Selma Levin				Month 4	Bay	2012	9:47	РМ
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Rethe		ath	4c. County		•••	
	Funeral		7420 Westlake Terrace 5. Social Security Number 6. Sex 7. Age (In yrs. I.	ast birthday)	If Under 1 Year	If Under 24 H		th	gomer 9. Birthp	lace (State or	r Foreign
	Director	i l	085-03-8677 1 ☐ M 2 🗓 F 94 Usual Residence of Decedent	Yrs.	Months Days	Hours Mi	n. (Month, Da		Count	ry) Iew Yor	rk
	land show	tor		ty, Town or Lo					10	0d. Inside Cit	
	Mary 28a-	Director	FL. Broward	Pon	npano Bea	ch				1 🗌 Yes	2X No
	vith th	ral	10e. Street and Number 821 Cypress Blvd., #304		10f. Zip Code 33069			10g. Citizen of V		•	
	eath w	Funeral	11 Marital Status 12. Was Decedent Ever in U.S	S. 13. \	Nas Decedent of Hi	ispanic Origin? (Specify Yes or No-		ce - America		
39	s after de al", or it	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		f Yes, specify Cuba 1 ☐ Yes 2 🏖 No		erto Rican, etc.)		ck, White, e		
2-0	hours'natur	olete	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occup kind of work done o		orkina	16b. Kind of B	usiness/Inc	lustry	
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d 2	led wi Hygie other ent, tl	ادہ ا	17. Father's Name (First, Middle, Last)	_ nome	JIMERCI	18. Mother's N	lame (First, Middle,				
/lan	d be fi Mental arked atic ev	욘	Robert Abramson			Sarah	Markman				
Aan	shoul	13	19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street a					,	
e, N	and 2 Health tem 27		Richard Levin - Son 20a. Method of Disposition 20b. F		Willowb sition (Name of	rook Dr	., Potoma	20c. Location			
mor	bage 1 ent of nt: If it		1 XBurial 2 Cremation 3 Removal from State	cemetery, cren	natory or other place em. Garde			Olney,	•		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Edward Sage 1	1 22	2. Name and Address	ss of Facility	Edward Sa	agel Fun	eral	Direct	
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	the Hospital or Attending Physician: The law requires that the death certificate thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy mpletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🗓 No 9 ☐ Unknown		Other (specify)	·		Mo	onth	Day Y	'ear
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Ζ	Physician: T this certifica ral director, p	은	1 Yes 2 X No Hospital: 1 Inpatient 2				Home 5 🕅 Reci			ence	
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Ö	spital of ours a neral D	edical (29a. Certifier 1 XCertifying Physician: To the best of my know	rledge, death r	occurred at the time	e, date and plac	e, and due to the c	ause(s) and man	ner as state	ed.	
	he Ho iin 24 h he Fui	Med	(Check 2 Medical Examiner: On the basis of examination only one) 3 Centifying Nurse Practitioner: To the best of t	n and/or invest	tigation, in my opinic	on, death occurre	ed at the time, date a	and place, and du	ie to the cau	ise(s) and mar	ner stated.
	Vith To 4		29b. Signature and title of certifier		29c. License			29d. Date signe		Day, Year)	
	H		30. Name and address of person who completed cause of death iten	222) (5: '		5317		4-10-20	12		
			John Wallmark, MD - 6420 Rock	ledge I	Orive, #4	200, Be	thesda, 1	Maryland	2081	.7	
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4-8-12

Levin, Solma

			State of Maryland / Dep	artment of Health and N	Mental Hygiene
			Trogramma.	rtificate of Death	Reg. No. 20 2 3 80
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death Month Day Year 4 8 2012 2:35 P M
	Medic Examin		Lois Leibel 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4 8 2012 2:35 P M
	⊏xamın	er	11506 Broadview Road	Silver Spring	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director	,	229-24-4244 1 □ M 2 🗓 F 86 Yrs.		9-8-1925 Virginia
	and show	'n	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	Maryl 28a-f otifiec	Director	MD Montgomery Silver Sp	ring	1 🏻 Yes 2 □ No
	th the		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wi	Funeral	11506 Broadview Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20902 Was Decedent of Hispanic Origin? (Spe	United States ecity Yes or No- 14. Race - American Indian,
9	er de	by F	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.
8	urs af tural", al Exa		3 A Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2 🛣 No Specify:	Specify: White
15	72 ho n "nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing 16b. Kind of Business/Industry
21215-0036	within giene. er tha the N		Elementary/Secondary (0-12) College (1-4 or 5+)	teer - Activist	Social Work
nd	filed valued of other sevent,	o Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Surname)
yla	uld be I Ment narke	우	Charles Hyman Lutins		Silverman
Mai	ie 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1	•	al Route Number, City or Town, State, Zip Code) e., Ashton, Maryland 20861
ē,	1 and of Heal item		20a. Method of Disposition 20b. Place of Dispo	osition (Name of	Date 20c. Location - City or Town, State
<u>m</u>	Page 1 ment of ant: If it ury or o			natory or other place) d Mem. Grdns 4-10	-2012 Falls Church, Virginia
Baltimore, Maryland	permit. Page 1 Department of Important: If it any injury or o once.		Dawara Bagor		ward Sagel Funeral Direction
	00 = 00		M00910 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent		e, Rockville, Maryland 20852 or respiratory arrest, Approximate
	Physician/		shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
	Medical	6 1	disease or condition resulting in death) Metistatic Ovaria Due to (or as a consequence of):	n Cancer	9 Months
	Examiner	L	Sequentially list conditions, b.		
	р (5	Examiner	if any, leading to immediate Due to (or as a consequence of): cause: Finish Indonying Cause (Disease or injury		
	xecute n and al-tr		that initiated events resulting in death) Last C. Due to (or as a consequence of):		
9	death certificate be executed ne attending physician and sed for use as the burial-true	Physician/Medical	d		
876	rtificat ing ph e as th	/Mec	IF FEMALE:		
Box 687	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
W		hysi	1 Yes 2A No 9 Unknown		
P.0.	that I	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ds,	equires				1 Yes 2 X No 3 Probably 4 Unknown
Records,	law re has bo	Completed			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
	sician: The law of certificate has k	e Co	25. Was case referred to medical	26. Place of Death (Check	1 Yes 2 X No 1 Yes 2 No
Division of Vital	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor	ome 5 X Residence 6 Other (Specify)
ot	th. After this of funeral directions		27. Manner of Death 1 XNatural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time o	f 28c. Injury at work?	28d. Describe how injury accurred
ion	ttendi death. tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	206 Lauria Churchard Mustana D. 15 A. Mustana
<u>X</u>	al or Attend safter death Director: A d in by the f		4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eer, ractory, onice	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detact	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invest		nd due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s) and manner stated.
	the H thin 24 the Fi	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	e, death occurred at the time, date and pla	ace, and due to the cause(s) and manner as stated.
	P. S. S. S. S.		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	٦		30. Name and address of person who completed cause of death (Item 23a) (Type,	D0033293	4-9-2012
			Frederick Smith, MD - 5454 Wisconsin	Avenue, Ste#1300	, Chevy Chase, Maryland 20815
	Stat Registra		31. Date filed (Month, Day, Year) APR 13 2012	del.	
	registre	ar .	MIN TO COLC (MARKED NO. 1990)		

		•	For State Registrar	State of Marylan		artment of H rtificate of L			ene 2012	13481
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
No.	/Medic	al -	DOLORES E. LOKEY 4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Deat	APRIL 9,	2012 4c. County of Deat	11:00 P ^M
d.	Examin	er	AMEDISYS HOSPICE #			WARWICK			CECIL	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	Ven	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign untry)
	Director		222-16-8794 Usual Residence of Decedent		84 Yrs.			04/14/19	27 DELA	AWARE
	yland		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	8a-f e	Director	DE NEW CASTL	E WILM	INGTO					1 ☐ Yes 2X No
	with the or 2		10e. Street and Number			10f. Zip Code 19809			Citizen of What Co	·
	death ms 23	Funeral	505 MARION AVENUE 11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race - Ame Black, Whit	nican Indian,
9	or its		1 Never Married 2 Married	1 Yes X No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 X No	Specify:	to ricall, etc.)	Specify:	e, etc.
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "natural", or items 23e or 28e-f ehow imatic event, the Madical Exeminar must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ		16a, Dece	dent's Usual Occup	ation	16	b. Kind of Business	ITE Industry
215	hin 72 3. 8n "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give life.	kind of work done of DO NOT use retired	during most of wo	orking		,
2	filed with Hygiene other the	Com	12	comego (. tor or,	HOMEM	AKER			WN HOME	<u> </u>
and	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma	uden Sumame)	
ي	should nd Men nmarks	ဥ	CHARLES H. LOKEY 19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili		JESSIE E and Number or R	ural Route Number, (City or Town, State, 2	Zip Code)
	d d d d d d d d d d d d d d d d d d d		MARK TAYLOR / FRIE	ND	505	MARION AV	ENUE WII	MINGTON,	DELAWARE	19809
altimore,	permit. Pages 1 an Department of Heel Important: If Item 2 eny injury or other 9000.		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Re	moval from State	emetery, cre	osition (Name of matory or other place			c. Location - City or	
Ē	it. Pa	1	4 Donation 5 Other (Specify) 21. Signature of Facility License					1/11/2012		
Ba	Depa Impo eny i) Lest file	you				IN & NEWNA MILLINGT		HOME, P.A. AND 21651
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deatle cause on each line.	h. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	Demo	rtia					ynknum
	/Medical Examiner			Due to (or as a consequ	uence of):					
0		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	uence of):					
	scuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
58760,	icate be executed physicien and s the burial-transit	al E	Toodiling in doubly East	Due to (or as a consequ	uence or):					
687		edical	d.							
ŏ	The law requires thet the death certificate hes been signed by the attending plage 2 should be detached for use as	Physician/M	236. was decedent pregnant	Sc. If yes, outcome of pregna 1□Live birth 2□Feta		□Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
P.O. Box	the at	ysici	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	eath 5[Other (specify)			WORKS	Day Fbai
	uires thet the de signed by the a Id be detached f		Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires been sign should be	ed by						1 🗆 Yes	2 □ No 3 □ P	robably 4 dunknown
eco	lawre es bei 2 sho	Completed						24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
<u>~</u>	ıysicien: The lav iis centificate hes director, page 2							performe	death? No 1 ☐ Yes	; 2□ No
⋚	sicient certifi irector	Be	25. Was case referred to medical examiner?	ospital:	ED/Outpatio	nt 3 DOA Oth	00	eath (Check only one) Home 5 Residen	on 6 DOther (Con	-41
٥	Attending Physicien: r death. ector; After this certifics by the funeral director, p	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how		Cnyy
sior	eath. or: Afi	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(1001/21, 22) 7 62)	lary		Yes 2 □No			
Division of Vital Records,	- 9	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	treet, factory, office		City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, dea	th occurred at the tir	ne, date and place	ce, and due to the cau	ise(s) and manner a	s stated.
	the Ho iin 24 I the Fu	ledicai	one)	er: On the basis of examina and manner stated.	ition and/or in	nvestigation, in my o	pinion, death occ	curred at the time, dat	e and place, and du	``
		Σ	29b. Signature and title of certifier	c max		29c. Licens	a number	296	d. Date signed (Mont	
,	3		30. Name and address of person who con	mpleted cause of death (Item	n 23a) (Tvpe	, Print)	, 0.0)		1110.0	2014.
_	Rin		S.S SACHDEV	MD, 126A	EH	igh ST.	ELK	Ton Mi) 2/92/.	
	Sta Registi		31. Date filed (Month, Day, Year)	S M) mpleted cause of death (Iten 32. Registrar's Signa	ature	hass				
	riegist	-1	110 66 20 27 66	14 Destina	10. 1	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 DAVID MAIA FERREIRA LAMBERT APRIL 12:21 AM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CRUMPTON 208 FRONT STREET **OUEEN ANNE'S** Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

CT Funeral 8. Date of Birth 1 X M 2 🗆 F (Month, Day, Year) 03/30/1925 Hours **Director** 218-16-7697 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No. **OUEEN ANNE'S** CRUMPTON MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 208 FRONT STREET 21628 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. o 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates. 1973 WHITE or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ATTORNEY 6 Be uld be filed with Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK LAMBERT BARBARA MURLLESS and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i CLARE LAMBERT / WIFE 208 FRONT STREET CRUMPTON, MARYLAND 21628 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 04/05/2012 STEVENSVILLE, MARYLAND 21. Signatur of Funeral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a, Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Interval Between Onset and Death Provident SEVERE HORTIC STENOSIS disease or condition month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to jor as a consequence of cause. Enter Underlying physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No ed by the a 9 Unknown g Unknown Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE RENAL 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed? Yes 2 No certificate 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 3 Suicide 5 Pending s after death.

I Director: Aff
d in by the fur 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral npleted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DOU41587 2012 2 Name and address of person who completed estertaun. MD 21620

State

Registrar

1

			For State of Mar State of Mar Registrar		artment of H rtificate of L			ene g. No. 2012	2 13483
В	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Year	3. Time of Death
Š.	/Medic	al	Frances T. LAWE 4a. Facility Name (If not institution, give street and number)	•	4h City Town or	Location of Death	APRIL	4c. County of Deat	
~	Examin	er	St. Joseph's Nursing Home			nsville		Baltim	
j.	Funeral		<u> </u>	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign puntry)
12.	Director		213-03-7219 Usual Residence of Decedent	97 Yrs.			July 2,	1914 Mai	cyland
	yland now at			10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar 3a-f st tiffied	Director	MD Howard	Ellic	ott City				1 □Yes 2yv No
	with th		10e. Street and Number		10f. Zip Code	2		og. Citizen of What Co	
	leath ns 23	Funeral	4730 Parkvale Road 11. Marital Status 12. Was Decedent Ev	ver in U.S. 13.1	2104 Was Decedent of Hi If Yes, specify Cuba			United Sta	rican Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married If Yes Give)	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, Whit	e, etc.
5-0036	hours tural", al Exa	ed by	3 √Widowed 4 □ Divorced Year or Dates:		dent's Usual Occup			₩] 16b. Kind of Business	nite
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2121	ed with	Be Completed	8	. 1	memaker		<u> </u>	Own Home	
Maryland	be file	Be	17. Father's Name (<i>First, Middle, Last</i>) John Jarkiewicz			18. Mother's Name		•	
Ž	should nd Me mark matic	욘	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a		aryanna al Route Number,	City or Town, State,	Zip Code)
<u>8</u>	alth ar		Barbara Sarnecki/Daughter	4730	Parkvale	Road El	licott C	City, Mary	Land 21043
Itimore,	es 1 a of He if Item or othe		20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other plac	ce)		20c. Location - City or	Town, State
Ĕ	t. Pag tment tant: I		4 Donation 5 Other (Specify)	Holy Cros		-1		Brooklyn Pa	
Bal	permi Depa Impo any Ir		21. Signature of Funeral Service Licensee					cott City	mily FH Inc.
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not ent					Approximate Interval Between
ĝ.	Physician		Immediate Cause (Final disease or condition	odis/	INFO	Alon			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a	consequence of):	or ten	1 D	1 40-04	Α.	
		Je.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
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60,	icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a	consequence of):					
68760,	ficate I physi s the k	edical	d						
Вох	eath certificate be executed attending physician and for use as the burial-transit	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2	f pregnancy	□Ectopic pregnancy	,		23d. Date of de	
	e deat the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)			Month	Day Year
P.0	that the	, Ph	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
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	siclan: The law s certificate has b lirector, page 2 s	Com					perforr	ned? death? 2No 1 □ Yes	_
Vita	slclan certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No Hospital: 1 ☐ Inpatien	ıt 2 ☐ ER/Outpatiei	nt 3 DOA Oth	26. Place of Death er:		-/	
0	g Phy er this ieral di	<u>ان</u>	27. Manner of Death 28a. Date of Injury	/ 28b. Time o				ence 6 Other (Spe ow injury occurred	эспу)
ior	endln ath. or: Aft he fun	atio	2 Accident investigation	injury		Yes 2 □ No			
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or Fi n, State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certii within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1⊟Certifying Physician: To the best of						
	the Ho in 24 h the Fu	edical	(Check only 2 Medical Examiner: On the basis of one) and manner state				red at the time, d		
	With To 1	Σ	29b. Signature and title of certifier	- 8	29c. Licens	se number		9d. Date signed (Mon	th, Day, Year) 7 2-0/2
•			30. Name and address of person who completed causer of dea	ath (Item 23a) (Type	Print)	77611		Cotine	rette MD
	5		ETMUND P. TKA	CUIK	401 1	5 Cd drul	- Rd	In h	100 2178
	Sta		31. Date filed (Month, Day, Year) 32. R/gistrar	r's Signature	hared				
	Regist	dl	MINT I COIL VENER	~ p. 19	1400				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\mathtt{April}^{\mathsf{Month}}1$ Physician/ 2012 8:30 P Marguerite M. Lange Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mt. Airy Lorien Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, Year) Country Director 217-24-0936 1 🗆 M 2 🖾 F 82 11/29/1929 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at irector 10b. County 10c. City, Town or Location 1 Yes 2X No MD Frederick Mt. Airy Ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3016 Flag Marsh Rd. 21771 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 homemaker own home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William E. Harrison Bertha Louise Duffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important If item 27 is any injury or and Susan Fisher/daughter 203 West Manor Ct., Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 04/13/2012 | Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gar. 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final End Physician Congestive years Stag disease or condition Medical resulting in death) Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a somesquents of). Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Month Pregnant at time of death rthe a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Dunknown Division of Vital Records, Dapumonic Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 Yes 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar 29a. Certifier

31. Date filed (Month

3 29b. Signature and title of certif

Feinberg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

itt65Stratfeld

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

059423

29d. Date signed (Month, Day, Year)

Avor 1 12,2012

St Floor Mariotsville mo 21104

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 08° 2012° 2:05p M Anne C. Lord Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Citizens Care and Rehab Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8 Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 🗆 M 2 🏻 06-26-1919 92 578-46-1437 **Director** uzerne Cty,PA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Frederick MD Frederick 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 6351 Spring Ridge Parkway Apt#211 21701 United States death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Administrative Assistant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဥ Catherine Novak Stephen J. Salansky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5844 Slate Hill Place Frederick, MD 21704 Charlotte Lord/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 04-11-2012 Brentwood, MD 21. Signature Juneral Service Densee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FAILURE Immediate Cause (Final CONGESTIVE Physician) disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Exami that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ğ Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? the Hospital or Attending Physician: The Ihin 24 hours after death.

the Funeral Director: After this certificate h 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title APRIL, 09, 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE FREDERICK, MD SYED SAFFAR 801 31. Date filed (Month, Day, Year) APR 1 3 2012 32. Registrar's Signature

Registrar

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	_	For State Registrar 1. Decedent's Name (First, Middle,	<u></u>			ificate of l			Reg. No	201	2 348
Physiciar Medica			eNamara, Jr					2. Date of De Month April		2012 Year	3. Time of Death 6:45A M
Examine		4a. Facility Name (if not institution,	,				r Location of Deat	h	40	. County of Dea	
Funeral		9720 Byeforde F 5. Social Security Number	6. Sex 7. Ag	ge (In yrs. las		Kensing	If Under 24 Hrs			Montgo g. Bir	tholace (State or Foreign
Director		577-16-4800 Usual Residence of Decedent	1 X M 2 □ F	90	Yrs.	Months Days	Hours Min.	(Month, Da August	7, Year)	1921 Was	shington, DC
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23a cust be	Funeral Director	9720 Byeforde	Road			20895	5		Tug. Ci	tizen of What Co	
ritems ner mi		11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit	erican Indian,
ral", or	ed by	1 ☐ Never Married 2 XX Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 X Yes 2 If Yes, Give Year or Dates.	No WWII	1	☐ Yes 2【 No	Specify:				nite
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	To Be	17. Father's Name (First, Middle, La						me (First, Middle,		Surname)	
marke matic	-	Martin James 19a. Informant's Name/Relationshi		r.	10h Mailine	Address /Street	Gertr and Number or Ru	ude Eich			Codel
alth ar		Jean Elizabeth		fe			Road Ke				
or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Ki Removal from State	20b. Pla	ce of Dispos netery, crema	tion (Name of atory or other place	e) Apri	Date 1 1 1	20c. L	ocation - City or	Town, State
ortant injury e.	ŀ	4 Donation 5 Other (Scale)				an Crema	atory	<u> </u>		xandria	, Va.
any population		> Mu Aroll	1101313	, 			onsin Ave				0007
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nysician/ Medical		disease or condition resulting in death)	a. Cerebr			ccident					7 Days
xaminer	۱ پر	Sequentially list conditions,	b. Atrial			on					11 years
DE .	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequer	nce of):						
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ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live Birth			Ectopic pregnanc	N/			23d. Date of de	livery
the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a			Other (specify)	,,			Month	Day Year
e detac	by Ph	Part II. Other significant condition	ns contributing to death t	out not result	ting in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco (use contribute to	the cause of death?
en sign		Alzheimer's dis	ease, Aorti	.c val	ve rep		for stenosis	1 🗆	Yes 2	X No 3□P	robably 4 🗌 Unknown
has be	Completed	НВР						24a. Was auto		24b. Were au prior to death?	topsy findings available completion of cause of
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this cer	잍	examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death			R/Outpatient		4 ☐ Nursing F	lome 5 🗷 Resid			ify)
th. After s funera	cate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga		y, Year)	8b. Time of injury	28c. Injun work M 1 🗆		28d. Describe h	now injur	y occurred	
irector	Certificat	3 Suicide 6 Could n 4 Homicide determin	ot be		e, farm, stree	t, factory, office		28f. Location (S			ral Route Number,
	edical C	29a, Certifier 1 K Certifying I	Physician: To the best of	mv knowled	lge, death oc	cured at the time	. date and place.	and due to the ca	use(s) ar	nd manner as sta	ited.
the Fur	⋝∣	(Check 2 Medical Exonly one) 3 Certifying I		examination a	nd/or investig	ation, in my opinio	on, death occurred	at the time, date a	and place	, and due to the	ause(s) and manner stated
The Park		29b. Signature and title of codifier	2.4		0	29c. License D211				te signed (Month $i1\ 11$,	
	ŀ	30. Name and address of person w	ho completed cause of c	leath (Item 2	3a) (Type, Pri						
		Lee R. Penning					uite 50,	Betheso	la,Mo	1. 20817	7
State Registra	7	APR 13 201	2 Butter	ar's Signatur	face	1.					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ape, Cherlynn Marie McCarty 3.37 M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Min. Hours 219-52-2172 **Director** 1 🗆 M 2 💢 F 60 July 2, 1951 Maryland Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number J Hygiene. J other than "natural", or items 23a or vent, <u>the Medical Exa</u>miner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 829 Georgia Avenue 21740 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Harold William Domer Esther Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Carrie M. McCarty Daughter 829 Georgia Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ō permit. Page 1 Department of Important; If it any injury or c 1 🗆 Burial 2 Xcremation 3 🗆 Removal from State 04-16-12 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland Signature of Funeral Service Licensee ² Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Brady 21740 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Md. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC disease or condition Medical resulting in death) Due to (or as a consequence of Examiner RACT INFECTION Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the attending physician by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MULTIORGAN Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific **Division of Vital** 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 3 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 1 Natural 5 Pending work? Accident
Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

3M3 Date filed (Month)

P.O.

MERITUS

MED, CTR.

HACERSTOWN MU

12-02845 Stephen Mitchell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Dea	ath	3. Time of Death
ledical Exami		Stephen Kent MITCHELL					Month April 11, 2	Day Year 2012	1132 hrs
		 Fecility Name (if not institution, give street and number Meritus Medical Center)	4b	•	or Location of Dea	ath	4c. County of De Washington	
F			e (In yes Is	ast birthday)	Hagerstow If Under 1 Ye		Ire I B Date of Bi	rth (MM/DD/YYYY) 9. I	
Funeral Director		Para Comp	47	Yrs.	Months Da		lin.	For	eign Country)Maryland
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21215-0036 uld be filed within 7/ Mental Hygiene, marked other the	Comple	17. Father's Name (First, Middle, Last)			Hone	18.Mother's Nar	ne (First, Middle,	Maiden Surname)	
be fill bring H H	8	Stephen Emory Mitchell					nce Lee		
ID 21: should and Mc	유	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing A	ddress (Stre	et and Number o	r Rural Route Nur	mber, City or Town, Sta	ite, Zip Code)
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Ore ges 1 a frof Hit ther t		1 X Burial 2 Cremation 3 Removal from St	ate c	rematory or othe	r place)				· —
Baltimore, permit. Pages 1 ar Department of Hee Important: Wite Imjury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Ko	se Hill			17/2012	·	n, Maryland
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	ļ	Val-0 V						ineral Home	
Physician	٦	23a. Part I. Enter the disease, or complications that caused	the death.	Do not enter the	mode of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval
Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a consistence)			ase				Between Onset and Death
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Sox 6876 Jeath certificate e attending phy for use as the b	Ž	IF FEMALE: 23c. If yes, outcor 23b. Was decedent pregnant in the	ne of pregn		death 3	Ectopic pregi	nancy	23d, Date of delive Month	ery Day Year
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E E E	Physician/I	9 Officiown		- 441 - 1 - 44		alian la Danta	Dog Dida	obacco use contribute t	the same of death 0
P.G s that gned l	ক্র	Part II. Other significant conditions contributing to deat	1 But not res	salting in the unc	enying cause	given in Fart i.	1 Yes		obably 4 Unknown
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뉴 A 등 전		27. Manner of Death 28a. Date of Inju (Month, Day, Y	ry ear)	28b. Time of Inju		ury at Work?	28d. Describe I	how injury occurred	
SiOr Attend death ctor:	gŧ	2 Accident Investigation				Yes 2 No			
Division ppital or Attendi ours after death.	Certification:	3 Suicide 6 Could not be determined (Specify)	jury - At hor	me, farm, street,	factory, office	building, etc.	28f. Location (\$ or Town, S		Rural Route Number, City
		29a. Certifier 1 Certifying Physician: To the best of mone) 2 Medical Examiner: On the basis of examiner:							
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier	1		29c. Licens		uno, date	29d. Date signed (M	
	100	Celuis 1/	1			M.E.		April 12, 2012	
XX	ŀ	30. Name and address of person who completed cause of d	eath (Item :	23a)				I	
3		Zabiullah Ali, M.D. Assistant Medical Ex		•	timore Stre	eet, Baltimore	e, MD 21223		
Sta Registi	ate	31. Date filed (Month of Y1a 2012 32. Fegistra	r's Signatur	A franchis	A.A.				

State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 APRIL GEORGE JOSEPH MILLER 8:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 8320 BEAVER COURT CHESTERTOWN cial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F (Month, Day, Year) 06/22/1922 **Director** NEW YORK 169-12-3438 89 Usual Residence of Decedent show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shotraumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MARYLAND | KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8320 BEAVER COURT <u> 21620</u> UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. WWII Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **AERONAUTICAL ENGINEER** AIRCRAFT MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GEORGE MILLER MINNIE SHELHORN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau JEAN MILLER / WIFE 8320 BEAVER COURT CHESTERTOWN, MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 04/02/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME.
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Alsheimers Physician/ 3 years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 the attending phone IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Year detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Adenocarcinoma Elthe Colon Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law cate has to autopsy performed? Yes 2 No After this certificate funeral director, page 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Yes ည 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director. /
completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 5105/5/4 D0050996 5 person who completed cause of death (Item 23a) (Type, Print) Neil Stodd and MI 100 Brown St Chastertown MD 21620 Year) 32. Registrar's Signature 1541 A Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Antonio, moscatelli Month 1734 04 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Battimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min 212-64-3631 **Director** 1 🛛 M 2 🗌 F 77 Usual Residence of Deced Oct. 9,1934 Egypt fshow or 28a-f shov notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Mt. Airy Carrol1 è Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 2270 Flag Marsh Road 21771 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Federal Government permit. Page 1 and 2 should be filed with Department of Health and Mental Hygies Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Giacomo Moscatelli Anna Moscatelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Moscatelli / Wife 2307 Flag Marsh Road, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 4/16/12 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause the t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition owere stenosis antic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 XNo မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending n 24 hours after death. e Funeral Director: Aft bletely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical within 24 hor To the Funel completely fi 29a. Certifier 1 ZCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Magela DeRidder 1629377809 04/08/2012

ろ | State

31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

University of maryland Medical Center 22. S. Greene St Baltimore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3491 State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 8 2012 Geneva 6:55 PM Thelma Moore Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George 14603 Duckett Road Brandywine 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 578-56-1596 Director 1 M 2 X 97 July 29, 1914 West Virginia Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits irector 1 X Yes 2 No MD. Prince George Brandywine ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14603 Duckett 20613 United States Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: If Yes. Give Specify: 3 ★ Widowed 4 □ Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **IBEW** Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Myers Nannie Lou McClure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Moore (Son) 14603 Duckett Road Brandywine, MD. 20613 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4/13/2012 | Waldorf, MD. Trinity Memorial Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home once, <u>ოდცედ 3035 01d Washington Road Waldorf, MD. 20601</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Operated and Death Immediate Cause (Final Physician) bedridden State disease or condition Medical resulting in death) Examiner Cerebrovascular disease of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-transit UNKNOWN that the death certificate be executed Nypertension that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 as the attending IF FFMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month ed by the a 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a, Was an page 2 has autopsy perform this certificate Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No 4 Nursing Home 5 X Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pendina 24 hours after death. Funeral Director: Af Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🎾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature ule mo Name and address of person who completed cause of death (Item 23a) (Type, Print)

Office No. 23348 Nicholson 23348 Nicholson Steet Housywood, MD. 20636 APR 1 6 2012

Registra

			For State State Registrar	of Maryland / [Depa <i>Cen</i>	rtment of Hea tificate of Dea	alth and N <i>ath</i>			12 3492
Dhun	:-:-	,	Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
Phys Mo	edic		George E. Mountain					Month 04	Day 12 20	012 7:06p ^M
Exa	mine	er	4a. Facility Name (if not institution, give street and no	umber)		4b. City, Town, or Loc			4c. County of [
Fune	ral		2805 Kingsway Rd 5. Social Security Number 6. Sex	7. Age (In yrs. last birtl	hdav)	Fort Wasl		8. Date of Birt		Birthplace (State or Foreign
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anylar 3a-f sl		ecto	MD Prince George'							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
the M		₫	10e. Street and Number	1010		10f. Zip Code			10g. Citizen of Wha	
h with 1s 23a nust b		Funeral Director	2805 Kingsway Rd			20744			USA	
r death			Armed		13. W	as Decedent of Hispa Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
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Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other		- 1	1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	n State cemeter	y, crem	atory or other place)		0-2012	Cholton!	
Baltimo permit. Page Department of Important: If any injury or	ej Se	ł	21. Signature of Funeral Service Licen	Maryi	_	Veterans Name and Address of		J-2012	Cheltenh Clinton	, MD 20735
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8/60 tificate b ng physi as the b		Med	F FEMALE:							
Box 68 death certifi he attending ed for use as	Ĭ.	ian/	23b. Was decedent pregnant 23c. If yes, or	itcome of pregnancy Birth 2 Fetal death					23d. Date of	,
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dS, quires en sig ould b								1 🗆 Y	es 2 ☐ No 3 ☐	Probably 4 Unknown
Kecords, The law requires ate has been sig		Completed						24a. Was a	sy prior	autopsy findings available to completion of cause of
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tendii death. tor: Ai		Certificate;	2 Accident Investigation 3 Suicide 6 Could not be			M 1 Nes				
DIVISION tal or Attendir s after death. al Director: Af ed in by the fu		5	4 Hamicide determined 266. Place	e of Injury - At home, farr ling, etc. (Specify)	m, stree	t, factory, office	1	28f. Location (St City or Town	reet and Number or , State)	Rural Route Number,
DIVISION OF VITAL RECORDS, P.O., In the Hospital or Attending Physician: The law requires that the within £4 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.		Medical	29a. Certifier 1 Certifying Physician: To the	best of my knowledge, d	eath oc	cured at the time, date	e and place, and	due to the caus	se(s) and manner as	stated.
the H thin 24 the Fr			(Check 2 Medical Examiner: On the base only one) 3 Certifying Nurse Practioner	sis of examination and/or To the best of my knowle	investig edge, de	ath occurred at the time	e, date and place	, and due to the	cause(s) and manner	as stated.
No Wit		2	9b. Signature and title of certifier	and W		29c. License num	DAI -	2	9d. Date signed (Mo	nti, Day, Year)
16.			0. Name and address of person who completed cau	se of death (Item 23a) (To	ype. Pri	nt)	0.0		1113	114
pu +1			Amir Mirzaalikhani, M.D.	.101 Centennia	1 St	reet, Suite I	B LaPlata	, MD 2064	5	
S Regis	state strar	3	1. Date filed (Month, Bar Year) 6 2012 32	Registrar's Signatur	pa	Kel				

			For State of Marylar				d Mental Hy	giene	
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eatri	2. Date of De	Reg. No	12 13433
	Physicia		Marianne Lee Manning				Month A		3. Time of Death 3:01 A ^M
-Ang	Medic Examin		4a. Facility Name (if not institution, give street and number)	· · · ·	4b. City, Town, or I	Location of De	eath	4c. County of	
-	/		9825 Bishopville Rd.		Bisho			Word	cester
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (in yrs	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		rth ay Year) 1939	Birthplace (State or Foreign Country)
			213-38-4246 72 Usual Residence of Decedent	110.			111/28	/1939	MD
	/land f sho	tor	10a. State 10b. County 10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mar 28a- notifie	Director		shopvi					1 🗆 Yes 2 🖾 No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at		10e. Street and Number		10f. Zip Code 21813			10g. Citizen of Wh	at Country?
	ems arr mus	Funeral	9825 Bishopville Rd. 11. Marital Status 12. Was Decedent-Ever in U.	S. 13. \		panic Origin?	(Specify Yes or No-	USA 14 Bace	· American Indian.
9	ter de , or it	by F	1 ☐ Never Married 2 ☐ Married		Nas Decedent of His f Yes, specify Cuban		ierto Rican, etc.)	Black,	White, etc.
003	urs af tural" al Exa	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1	I□Yes 2XINo	Specify:		Specify:	white
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ylaı	ld be Menta rarked atic e	욘	William A. Plummer			Kat	hryn She	eetz	
Maryland 21215-0036	should I and Me		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street an			-	
e,	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	- 13	William Curtis (son) 20a. Method of Disposition		Bishops sition (Name of	<u>ville</u>	Rd., B:		le, MD 21813
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State	cemetery, cren	natory or other place,			20c. Location - C	
ati	permit. Page 1 Department of Important; If it any injury or c		21. Signatur of Funeral Service Licensee		. Name and Address			Funera	onville, MD
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			23a. Part J. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not ente	er the mode of dying,	such as card	liac or respiratory ar	rest,	Approximate Interval Between
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	To the Hos, ital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the uneral director, page 2 should be detached for use as the burial-transition.	Medical	(Check Medical Examiner: On the basis of examination	n and/or investi	igation, in my opinion,	death occurre	ed at the time, date a	ind place, and due to	the cause(s) and manner stated.
	To the I within 2 To the I comple:		29b. Signature and title of certifier		29c. License n			29d. Date signed (A	
			> Stemins		1587	88		April 4	12012
RI	A 15		30. Name and address of person who completed cause of death (Item	23a) (Type, Pr 4	e Chrisco	x Dvi	re Be	-lin Mi	
	Stat		31. Date filed (Month, Day, Year) APR 1 2 2012 32. Registrar's Signat	ture 1	arles	,			,
	Registra	r	ATK I G CUIC Geneva	s. popla	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g926 4-30-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2012 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 10:50 A.M Lena Lorraine McIlwee 03 15 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Allegany** Moran Manor Nursing Home Westernport Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs, last birthday, 8. Date of Birth (Month, Day, Year) Hours **Funeral** Days Months 1 □ M 217 F Yrs. 95 July 30, 1918 West Virginia 234-58-1257 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 1 XYes 2 □ No WV Director Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 with 396 Ward Avenue 26726 USA Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or Items the Medical Examiner mu 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specity White Specify: ρ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha (Howdyshell) Bean 2 Amos Bean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. Paul McIlwee, Son 192 C Street Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Potomac Memorial Gardens 03/19/2012 Keyser 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oranno Dizense **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any localing immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VASculor 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Sinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Jas autopsy page performe certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Thursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours afte To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar Jesus Tan

31. Date filed (Mont)

4 Broadway St. Frostburg, Md. 21532

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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12-03015 Robert Moreland amend 26, per me, g927 5-11-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	· ≱ £ 8	Me											r, Year)
	J	f					more Street	, Baltimor	e, MD 2	1223			

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2) Nonth Physician/ 2892 Mason Beulah Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Allegany WMHS-RMC Cumberland 9. Birthplace (State or Foreign Country) MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Mar 133, 1918 217-10-5713 94 Director 1 M 2 XF Usual Residence of Decedent show 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director Cumberland must be notified MD Allegany 28a-f 1 X Yes 2 No 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? Funeral 23a 21502 730 Furnace Street USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?
1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced white event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) It of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) retail salesperson GC Murphy Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Effie Jane Baker Alfred B. Mason 19a. Informant's Name/Relationship (Type, Print)

Jane Allmaras Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5564 Frog Pond Lane Virginia Beach VA 23462 niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or c 1 Burial 2 Cremation 3 Removal from State Hillcrest Memorial Park 4/18/2012 MD Cumberland Donation 5 Other (Specify) of Funeral Service 22. Name an carpelli full Eral Home, PA ignatu 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TERIOSC Playsician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Day Year Pregnant at time of death signed by the at the detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

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Registrar

DHMH 17 Rev 06-2011

State

(Type, Print)

200 Glenn St. Ste 362

Cumberland MD

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

APR 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 5:00A M Bruce Eugene Newcomer 2012 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 17053 Old Baltimore Road Olney If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Apr. 11 Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Washington, D.C. 60 Ť951 216-58-0958 **Director** Apr Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director 1 Yes 2 X No Olney MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 United States 17053 Old Baltimore Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Fire and Rescue Paramedic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Anna Weikert Joseph L. Newcomer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19805 New Hampshire Ave., Brinklow, MD 2 19a. Informant's Name/Relationship (Type, Print) Linda K. Newcomer / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State injury or permit. Page Department of Important; If any injury or Ringgold Cemetery 4/14/12 Smithsburg, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Laytonsville, Maryland 20882 P. O. Box 5038, Co 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause iDisease or ilniury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year, April 10, 2012 D 37142 30. Name and address of person who completed cause of death (Ite (Type, Print)

State

Geoffrey Coleman, M.D.

31. Date filed (Month,

Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

1355 Piccard Drive, #100, Rockville, Maryland

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Mary Elizabeth Owen 10:25pm April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Washington Rockville Montgomery Hebrew Home of Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Hours Min Month, Pay, / Director Washington 531-22-8859 86 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examinar minet has actived any injury or other traumatic event, the Medical Examinar minet has actived. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 20852 6121 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) International Affairs Special Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roberta Rauch John Owen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2139, Vashon, Washington 98070 Marilyn W. Newland - Purchaser 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 04/16/2012 Brentwood, Maryland 21. Sign ture of Fundal Southe Lion 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. New Hampshire Ave. Silver Spring. MD 20904 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ EUMUN Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 been signed by the attending physician and should be detached for use as the burial yransit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has perform 2 🗌 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 욛 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pfint)

Registrar

32. Registrar

2012

13

			For	State of	Maryland			lealth and M			1.0	10100
			State Registrar	4)		Cer	tificate of D	Death		g. No. 20	12	13499
	Physicia Medic		1. Decedent's Name (First, Middle, L Erdogan Res	,					2. Date of Death April 9	, Day 2012	Year	3. Time of Death 2:31 P M
	Examin	er	4a. Facility Name (if not institution, gi Anne Arundel Me					Location of Death	7	4c. County o		nde1
	Funeral Director		214-36-9923	Sex 7. 1 M 2 F	Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)	Year)	g. Birthpl Countr Turk	
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	rundo1	10c. City	, Town or Loc		polis			10	od. Inside City Limits
	death with the Maryland ritems 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number				10f. Zip Code	21403	10	Og. Citizen of Wh	nat Count	
	death wit items 23 ier must	Funer	283 Spa Creek I	12. Was Decede Armed Force	nt Ever in U.S.	. 13. V	Vas Decedent of Hi	spanic Origin? (Spe	cify Yes or No-	14. Race		
JU36	urs after o ural", or Il Examir	ted by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Date	X No		Yes 2 X No			Specify:	White, e	
9500-61212	be filed within 72 hours after death with the Maryland antal Hygiene. Red other than "natural", or items 23a or 28a-f show ked other than "natural", or items 2a or 28a-f show to event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		or 5+)	(Give k life. DC	NOT use retired)	luring most of worki	ing	16b. Kind of Bus		ustry
2	ed with Hygier other t ent, th	Be C	17. Father's Name (First, Middle, Last			Physi	ician OB/	18. Mother's Name	Eirst Middle M	Medic	uk	n
Maryland	should be file and Mental is marked of aumatic eve	Tol										
, Mai	25 5	- 53	19a. Informant's Name/Relationship Nancy O'Brien -		, ,	19b. Mailin 205 V	g Address (Street a Vincheste	r Beach I	or, Annar	olity or Town, Sta	10 21	409
Baltimore,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 4 🗀 Donation 5 🗀 Other (Spe	☐ Removal from St	oto Ce	emeterv. crem	sition (Name of patory or other place s Cemete	ery 4/14	- 1	20c. Location - C Annapol		
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lies	Willer	\			of Glouces				
	E-14000		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	. Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arres	t,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	d	as a conseque	ence of):					H	ours
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	as a conseque						+	ارچو)
	te be executed tysician and he burial-transi	l Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):						
2	ate be hysicia the bu	dical		d								
20 x 08/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		th 2 🗀 Fetal nt at time of de	death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont		y Day Year
S, P.O.	ires that th signed by	ρ	Part II. Other significant conditions	contributing to dear	th but not resu	ulting in the u	nderlying cause giv	en in Part I.				e cause of death?
Vital Records,	he law requite has beer bage 2 shou	Completed	Ischenic CARD	CAILURE	TH T				24a. Was an autopsy perform	pri		sy findings available apletion of cause of
<u>.</u>	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?					ace of Death (Check		N		
>	Physic this or	은	1 Yes 2 No 27. Mapner of Death	Hospital: 1 Ing	patient 2 🗆 f	ER/Outpatien 28b. Time of		4 U Nursing Ho	me 5 Resider			
on of	eath. or: After the funer	Certificate:	Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not	(Month,	Day, Year)	injury	28c. Injury work M 1 🗆		28d. Describe hov	v injury occurred		
DIVISION	tal or Att rs after d al Direct led in by		4 Homicide determine	28e. Place of	Injury - At hor , etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,		or Rural I	Route Number,
	he Hospi in 24 hou he Funer pletely fill	Medical	(Check 2 Medical Exa	nysician: To the bes miner: On the basis urse Practitioner: To	of examination	and/or invest	igation, in my opinic	n, death occurred at	the time, date and	place, and due t	o the caus	se(s) and manner stated.
	Vith Com		29b. Signature and title of certifler		· ·		29c. License	2199	29	d. Date signed (Month, D	ay, Year)
	5w		30. Name and address of person who	o completed cause o			rint)	napolis, l	MD 21701	-1-14		
	Stat Registra		31. Date filed (Month, Day, Year) APR 1 2 20		istrar's Signatu	de da		ισδοττ2•	<u> 214U1</u>	•		
				7-7-1-		17						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Physician/ 2 Margaret Mae Ofte April 11:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death William Hill Manor Easton Talbot If Under 1 Year If Under 24 Hrs. Social Security Numbe 9. Birthplace (State or Foreign Country) Michigan 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** Days 1 🗆 M 2 💢 F Months Hours Min. 2/2/1927 85 **Director** 365-26-3173 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 52B Davis Lane 21601 · death v 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 1 Never Married 2 X Married þ Maryland 21215-0036 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Public/Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Haikes John Ray McHenney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Ofte, husband 52B Davis Lane, Easton, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oxford Cemetery 4/12/2012 Oxford, Maryland 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 South Harrison Street, Easton, MD 21601 21. Signature ral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ -chexla disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ber Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work s after death. 1 Yes 2 No 2 Accident Investigation filled in by the 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the F 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cept 29d. Date signed (Month, Day, Year)

State Registrar

RS10

508 Idlewild Avenue, Suite 5, Easton, MD

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Regi trar's Signature

Robert B. Sanchez,

APR 0 6 201

31. Date filed (Month